

***United States Court of Appeals
for the
District of Columbia Circuit***



**TRANSCRIPT OF
RECORD**

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CONSOLIDATED REPLY BRIEF FOR APPELLANT

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20,881
No. 20,962

Charles C. Rouse,

Appellant,

v.

Dale C. Cameron, Superintendent,
St. Elizabeths Hospital,

Appellee.

Appeals from the United States District Court
for the District of Columbia

United States Court of Appeals
for the District of Columbia Circuit

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I. INTRODUCTION

On October 10, 1966, this Court handed down a decision holding that Appellant had a right to receive adequate treatment while he was an involuntary inmate in St. Elizabeths Hospital, and remanded the case for further proceedings. Rouse v. Cameron, 373 F.2d 451 (1966). Appellee did not move for rehearing in this Court, either by the panel or en banc; nor did Appellee petition the Supreme Court for a writ of certiorari.

Pursuant to the Court's order, a hearing was held in the district court on the adequacy of the treatment afforded to Appellant and on his present mental condition. The district court held that Appellant was receiving adequate treatment and that he was not entitled to release on grounds of restored sanity. The appeal in No. 20,881 followed.

On May 17, 1967, counsel for Appellant filed a consolidated brief in Rouse v. Cameron, Nos. 20,881 and 20,962. The brief was premised on the assumption that the decision of October 10, 1966, as amended, was a binding precedent. On the same day that Appellant's brief was filed, this Court issued an order, sua sponte, setting this case for hearing en banc, and stating:

"To avoid any possible misunderstanding, counsel are hereby expressly advised that on the hearing en banc of Rouse v. Cameron, No. 20,881 and No. 20,962, counsel may request the court to reconsider and modify rulings made in Rouse v. Cameron, No. 19,863."

"Some members of the court" added that "all issues previously considered and decided by the court in Rouse v. Cameron, No. 19,863, are open for reargument and reexamination"

In view of the fact that the order of May 17 re-opens a number of issues that Appellant had thought were resolved by the October 10, 1966 decision, this brief supplements Appellant's first brief as well as responding to Appellee's brief.

The order of May 17 leaves the status of the Court's October 10 decision somewhat in doubt. Appellant takes the position that the October 10 decision states the law of the case. Zdanok v. Glidden Co., 327 F.2d 944 (2d Cir. 1964); 1A Moore, Federal Practice, ¶ 0.404 (1961). Hence, only "a clear conviction of error on a point of law that is certain to recur" should lead the Court to reconsider the rule of law previously established. Zdanok v. Glidden Co., 327 F.2d at 953. Appellee was free to seek review of the decision of October 10, 1966, but he did not do so. That decision states the law governing this matter. Furthermore, the

decision is entitled to great weight by virtue of its forceful logic and its already-established place in the jurisprudence of the District and the nation.

A. Recent Developments in the Law Relating to the Right To Receive Adequate Treatment

Appellee suggests that the Rouse decision of October 10 is an anomalous and improper judicial intrusion into the area of post-commitment treatment.^{1/} In fact, it is in the mainstream of legal development, a part of a growing judicial concern with the treatment problem.

This Court has long held that treatment of the individual is one of the basic purposes of commitment to St. Elizabeths Hospital under Section 24-301(d). See, e.g., Hough v. United States, 106 U.S. App. D.C. 192, 195, 271 F.2d 458, 461 (1959). In Ragsdale v. Overholser, Judge Fahy stated that Section 24-301

^{1/} Appellee urges the Court to take this opportunity "to undo a pernicious precedent before it can do further damage." Appellee's Brief 27a, text following n.24. Cf. In re Gault, 35 U.S.L.Wk. 4399, 4405, n.30, citing Rouse decision.

Appellee's Brief was served on Appellant's counsel after the close of business on June 13, 1967, in mimeographed form. Appellant's counsel are informed that Appellee intends to file a printed brief, but that the printed brief will not be submitted until after oral argument. All references herein to material in Appellee's Brief are identified by a footnote number as well as a page number in the mimeographed text.

" . . . rests upon a supposition, namely the necessity for treatment of the mental conditions which led to the acquittal by reason of insanity. And this necessity for treatment presupposes in turn that treatment will be accorded." 108 U.S. App. D.C. 308, 315, 281 F.2d 943, 950 (1960) (concurring opinion).

In Darnell v. Cameron, 121 U.S. App. D.C. 58, 348 F.2d 64 (1965), the Court stated that the

" . . . 'absence of treatment might draw into question' the constitutionality of th[e] mandatory commitment section as applied to appellant." 348 F.2d at 67-68.

In its en banc decision in Green v. United States, 121 U.S. App. D.C. 226, 349 F.2d 203 (1965), the Court held that a patient committed under D.C. Code § 24-301(d) had standing to challenge an order releasing him from St. Elizabeths Hospital. In support of this conclusion, the Court stated "a patient has a cognizable interest in securing the medical treatment which commitment is intended to assure." 121 U.S. App. D.C. at 228, 349 F.2d at 205. (Emphasis added.)

Since the Rouse decision, there have been a number of developments relating to matters of treatment. The treatment afforded to juveniles presents an analogous problem, since juveniles, like mental patients, are frequently deprived of their liberty by judicial action so that they can

be afforded psychological and psychiatric treatment. See Kent v. United States, 383 U.S. 541, 555 (1966). In its recent decision in In re Gault, 35 U.S.L.Wk. 4399 (1967), the Supreme Court expressed some doubt about "the adequacy of treatment afforded juveniles." Id. at 4405, n.30. In this connection the Supreme Court approvingly cited this Court's Rouse decision and several of this Court's other cases dealing with the adequacy of treatment of juveniles. Ibid.

Among the cases cited by the Court was Creek v. Stone, No. 20,563, opinion filed May 1, 1967. In the Creek case this Court unanimously held that the adequacy of the treatment afforded to a juvenile in custody in advance of a juvenile court hearing could be raised in the district court on habeas corpus. By way of illustration, the Court noted that a district court could properly order release if a juvenile were taken into custody for psychiatric treatment but none was afforded. Id. at 7. Upon allegations that a juvenile has "a need for treatment which is not being furnished," inquiry must be made to assure that the needs of "that particular juvenile . . . are being met." Id. at 8.

In re Elmore, No. 20,497, decided May 23, 1967, posed a similar problem. The juvenile court had found that Elmore

needed "'psychological and/or psychiatric care to meet his particular needs,'" id. at 3; Elmore alleged that he was not receiving such care and treatment. Citing Creek v. Stone, Rouse, and Tribby v. Cameron, No. 20,454, decided April 14, 1967, the Court remanded the case for appropriate inquiry into the adequacy of treatment. Id. at 3-4. Hence, this Court and the Supreme Court have in the juvenile area undertaken inquiries closely akin to the review of adequacy of treatment mandated by the Rouse decision of October 10, 1966.

In addition to Rouse, the Court has had a number of cases dealing with the adequacy of the treatment of mental patients. In Millard v. Cameron, ___ U.S. App. D.C. ___, 373 F.2d 468 (1966), the Court remanded the case for a hearing on the adequacy of the treatment afforded to a patient held as a sexual psychopath. D.C. Code §§ 22-3503 to 3509 (1961). In Tribby v. Cameron, supra, the Court remanded the case to the district court for a hearing on adequacy of treatment, affirming that:

"The conditions under which a person may be deprived of his liberty are the concern of courts as well as Congress and the Hospital." Slip opin. 2-3.

In Collins v. Cameron, No. 20,371, decided April 21, 1967,

the Court considered the adequacy of the treatment afforded Appellant and reaffirmed the fact that a central purpose of commitment to St. Elizabeths Hospital is treatment.^{1/}

The en banc decision in Easter v. District of Columbia, 124 U.S. App. D.C. 33, 361 F.2d 50 (1966), shows a similar concern with treatment in the analogous area of alcoholism. Holding that chronic alcoholism is a defense to public intoxication, the Court cited Robinson v. California, 370 U.S. 660, 665, (1962), for the proposition that "a program of

^{1/} No judge on this Court has stated that an involuntary patient in St. Elizabeths Hospital does not have a right to treatment which is cognizable on habeas corpus in the district court.

In his dissenting opinion to the October 10 Rouse decision, Judge Danaher stated:

"No member of this court has ever suggested that a person committed because of mental illness should not receive 'treatment.'" 373 F.2d at 466.

Stating that the majority opinion seemed "plausible," he objected that the majority was "deciding a case that is not before us." Id. at 462. Moreover, he concluded on his own review of the evidence that Appellant had received "extensive treatment." Id. at 466. Cf. id. at 466-67 n.14.

In the district court, the right to treatment has been recognized. In addition to the Rouse hearing, hearings have been held in the Millard case. In Hemphill v. Cameron, H.C. No. 66-67, the district court ordered the case continued for six months for new treatment efforts. Order of May 25, 1967.

For responses from the mental health professions, see 123 Amer. J. of Psychiatry 1458 (1967); 37 Amer. J. of Orthopsychiatry 455 (1967).

compulsory treatment" could justify involuntary confinement. 124 U.S. App. D.C. at 38, 361 F.2d at 55. Plainly, the treatment program would have to be meaningful and appropriate to justify confinement.^{1/}

Perhaps the most striking development since the Rouse decision is Appellee's recognition of a right to treatment. Appellee did not seek review of the October 10 Rouse decision. In Dobson v. Cameron, No. 20,573, and Stultz v. Cameron, No. 20,576, now pending, Appellee for the first time officially abandoned his rigid position that patients had no judicially cognizable right to treatment.^{2/} And in his brief in the instant case, Appellee takes the position that a patient committed under Section 301(d) has a justiciable right

^{1/} Chief Judge Harold H. Greene of the Court of General Sessions held that the courts should not send chronic alcoholics to a facility that is unsuitable for their treatment. District of Columbia v. Walters, Crim. No. D.C. 18150-66, decided Aug. 16, 1966.

Senator Tydings stated in this context:

"A judge who fails to make certain that adequate treatment is available, and sends an alcoholic to a treatment facility simply because it is there and it is not filled, is not discharging his judicial obligations in a wise and humane way."
113 Cong. Rec. H6006, May 23, 1967 (daily ed.).

^{2/} While Appellee's briefs argued that civil patients had to resort to administrative remedies first, he plainly indicated that the courts would have a proper reviewing function in passing on the adequacy of treatment. Brief of Appellee, Dobson v. Cameron, No. 20,573, pp. 32-33.

to receive treatment, albeit treatment of a rather primitive kind. Appellee's Brief 27a-27b, 48, text following n.24, at n. 56-59.

In light of this developing body of case law relating to the right to treatment, Appellee's position, and the further constitutional and statutory arguments developed herein, the Court should reaffirm the holding of the October 10 Rouse decision.

II. A PATIENT WHO IS COMMITTED UNDER SECTION 24-301(d) AND CONFINED IN ST. ELIZABETHS HOSPITAL WITHOUT ADEQUATE TREATMENT IS DEPRIVED OF HIS CONSTITUTIONAL RIGHTS.

Appellee resists the argument that the right to treatment section -- Section 21-562 -- applies to patients committed under 301(d); but he concedes that the due process clause guarantees them treatment^{1/} and that "Congress contemplated that persons committed to a mental hospital pursuant to 24 D.C. Code § 301(d) would be treated." Appellee's Brief 38, text preceding n. 37.

A. Due Process -- Cruel and Unusual Punishment

The purposes of confinement in St. Elizabeths Hospital after a finding of not guilty by reason of insanity have been succinctly restated as follows:

"We have consistently held that detention under D.C. Code § 24-301(d) is not punitive but rather serves a two-fold purpose: (1) to protect the public and the subject, and (2) to afford a place and a procedure to treat and, if possible, to rehabilitate the subject. Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 312, 281 F.2d 943, 947 (1960). See also Miller v. Cameron, 118 U.S. App. D.C. 323, 324, 335 F.2d 986, 987 (1964); Overholser v. O'Beirne, 112 U.S. App. D.C. 267, 268-74, 302 F.2d 852, 853-59 (1961)." Collins v. Cameron, No. 20,371, decided April 21, 1967 (D.C. Cir.), slip opin. 3.

^{1/} Appellee's Brief 27a-27b, 48, text following n.24, at n. 56-59.

Both purposes -- treatment and protection of the individual or society -- must be served if the commitment is to withstand constitutional challenge.

The concept of due process embodies a "notion of fair play and substantial justice." International Shoe Co. v. Washington, 326 U.S. 310, 316 (1945); see Solesbee v. Balkcom, 339 U.S. 9, 16 (1949) (dissenting opinion). There is no doubt that "confinement in a mental hospital is as full and effective a deprivation of personal liberty as is confinement in jail." Barry v. Hall, 68 U.S. App. D.C. 350, 353, 98 F.2d 222, 225 (1938). The treatment afforded the involuntary patient is the necessary quid pro quo for deprivation of personal liberty, when criminal guilt does not justify incarceration. See Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 315, 281 F.2d 943, 950 (1960) (concurring opinion); Darnell v. Cameron, 121 U.S. App. D.C. 58, 61-62, 348 F.2d 64, 67-68 (1965). To deprive a person of his liberty for the purpose of treating him, then fail to provide him with suitable and appropriate treatment is a deprivation of liberty without due process.^{1/}

^{1/} See Bassiouni, "The Right of the Mentally Ill to Cure and Treatment: Medical Due Process," 15 De Paul L. Rev. 291 (1966); Birnbaum, "The Right to Treatment," Amer. Bar Ass'n J., May, 1960.

Involuntary confinement in a mental hospital without treatment submits the person to cruel and unusual punishment in violation of the Eighth Amendment. The underlying concept of the insanity defense is that the defendant cannot be punished for his acts because he lacks mens rea. It is the treatment which he is afforded that justifies his incarceration and distinguishes the patient from the prisoner. It is inconsistent with humane values to punish the ill for their illness; any such punishment, for a condition which the sufferer did not choose and cannot voluntarily change, is cruel and unusual.

In Robinson v. California, 370 U.S. 660 (1962), the defendant had been convicted under a California statute making addiction to narcotics a crime. The Supreme Court held the law unconstitutional on the ground that punishment of addiction would violate the Eighth Amendment. Holding that drug addiction is an illness, one which "may be contracted innocently or involuntarily," 370 U.S. at 667, the Court stated:

"It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with venereal disease. A state might determine that

the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments." 370 U.S. at 666.

While the Supreme Court recognized the permissibility of confinement for treatment, the Court made it clear that treatment must in fact be afforded to justify confinement.

The District of Columbia Court of Appeals in Easter v. District of Columbia, 124 U.S. App. D.C. 33, 361 F.2d 50 (D.C. Cir. 1966), followed the Robinson reasoning in holding that chronic alcoholism is a defense to the charge of being intoxicated in a public place. The Court held that to punish the alcoholic in this situation would be cruel and unusual -- a punishment of a status involuntarily assumed. See also Driver v. Hinnant, 356 F.2d 761 (4th Cir. 1966).

B. Equal Protection of the Laws

The equal protection concept is made applicable to federal action by the due process clause of the Fifth Amendment. Bolling v. Sharpe, 347 U.S. 497 (1954). The guarantee of equal protection is designed to protect citizens from

disparate treatment under the law as a result of arbitrary and unreasonable classification. The Supreme Court has stated that equal protection requires "that a distinction have some relevance to the purpose for which the classification is made." Baxstrom v. Herold, 383 U.S. 107, 111 (1966). See also Reynolds v. Sims, 377 U.S. 533 (1964). In other words the purpose of a statute must bear a logical and reasonable relation to the rationale of the classification.

Appellee has urged this Court to read D.C. Code § 21-562 as applying only to civilly committed patients. Appellee's Brief 31-43, Section IB. As to 301(d) patients, Appellee states that their confinement need only be such that it does not shock the conscience. Appellee's Brief 48, text preceding n. 56. This argument implies that the standard of treatment afforded to civil patients under this section would be higher than the very minimal standard Appellee would require for treatment of 301(d) patients. Appellee's Brief 55, n. 69; Brief of Appellee, Dobson v. Cameron, No. 20,573, passim.

Appellant contends that Appellee's interpretations of the applicable statutory and constitutional provisions would, in their sum, deny him the equal protection of the laws. It

is impossible to justify a discrimination between civilly committed patients and 301(d) committees in St. Elizabeths Hospital with respect to their right to treatment. In all respects arguably relevant to treatment, the two classes are indistinguishable:

1. Both classes have been found to be dangerous to themselves or to others.
2. Both classes are thought to be sick and in need of treatment.
3. Both classes are to be held in the Hospital until they are recovered and no longer dangerous.
4. Neither class is more or less treatable than the other.
5. The purposes of 301(d) and civil commitment are to provide treatment and to safeguard the individual and society.

It is, of course, true that all 301(d) committees have been found to have committed an act that would have been criminal if they had not been of unsound mind. All civil committees have not been found to have committed crimes, but all have been found to be dangerous. And many civil committees have substantial criminal records.^{1/} The basic fact

1/ See, e.g., Brody v. Cameron, Nos. 20452, 20569, 20848, now pending.

is that a 301(d) commitment has absolutely no significance in relation to the matters of need for or amenability to treatment. Appellant would be denied the equal protection of the laws if the Court concluded that he did not have a right to receive treatment substantially equivalent to the treatment rights of civilly committed patients.

Whatever validity for other purposes there may be in the "special class" reasoning of Overholser v. Leach, 103 U.S. App. D.C. 287, 257 F.2d 668 (1958), cert. denied 359 U.S. 1013 (1959), 301(d) committees cannot be regarded as a special class, distinct from civil committees, for purposes of determining the treatment to be afforded them. See Appellant's Brief 36-41. Cameron v. Mullen, No. 20,308, decided March 2, 1967, slip opin. 9-15.

The Supreme Court in Baxstrom v. Herold, 383 U.S. 107 (1966), found a denial of equal protection in a similar situation. In Baxstrom the petitioner, while serving a prison term, was certified to be insane by a prison physician. The Court held that his pre-commitment criminal conduct did not justify depriving him of post-commitment rights without the procedural safeguards afforded to others. Specifically, the Court rejected the state's argument that prior criminal

conduct in itself was a constitutional ground for classification of Baxstrom as a patient who was to be assigned to Dannemora State Hospital, an institution for the dangerously insane.

The Supreme Court held such classification unconstitutional in connection with differing procedures for assignment to a hospital for the dangerously insane. The equal protection violation is even clearer in the instant case since past criminal activity is even less relevant to treatment than to such assignment.^{1/}

Appellee's attempts to distinguish the Baxstrom case from the instant case are unconvincing. It is true that Baxstrom was found guilty of a felony, and later found to be insane, whereas Appellant was found not guilty by reason of insanity on a misdemeanor charge. But that does not make it more reasonable to discriminate between Appellant and civil committees in matters of treatment than to discriminate between Baxstrom and

^{1/} In Cameron v. Mullen, No. 20, 308, decided March 2, 1967, this Court read Baxstrom as stating that a patient's prior criminal conduct cannot "provide an automatic basis for allowing significant and arbitrary differences in . . . conditions [of custodial confinement]." Id. at 14.

civil committees in assignment procedures. The fact that Appellant's hospitalization arose from a criminal proceeding rather than civil can have no significance for the treatment of the patient in the hospital. Baxstrom v. Herold, 383 U.S. 107, 111. See Carroll v. McNeill, 294 F.2d 117 (2d Cir. 1961); People v. Lally, 19 N.Y. 2d 27 (Ct. App. 1966).^{1/}

^{1/} The heart of Appellee's argument to distinguish Baxstrom is that Appellant's is a "criminal" commitment, and this fact justifies a wide range of differences in the procedures for his commitment, his treatment, and his release. The Supreme Court has recently warned against this infatuation with the civil-criminal dichotomy. Specht v. Patterson, 35 U.S.L.Wk. 4340, 4341. The Court plainly indicated that little significance should be attached to whether "commitment proceedings . . . [are] denominated civil or criminal," and cited Baxstrom as authority. Ibid. See also In re Gault, 35 U.S.L.Wk. 4399 (1967).

III. UNDER D.C. CODE SECTIONS 21-562 AND 24-301, APPELLANT HAS A RIGHT TO RECEIVE ADEQUATE TREATMENT.

As an alternative ground of decision, Appellant contends that Sections 21-562 and 24-301 guarantee to Appellant a right to receive adequate treatment while he is an involuntary patient at St. Elizabeths Hospital. Appellant contends the statutory right is coterminous with the constitutional right to receive treatment discussed above.

A. Section 21-562

On its face, Section 21-562 guarantees to Appellant a right to receive adequate treatment:

"Medical and psychiatric care and treatment; records.

"A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment."

In a lengthy and detailed analysis, Appellee has urged that the legislative history of the section negatives its plain meaning and renders it inapplicable to patients committed under Section 24-301(d). Appellee's Brief 31-43, text between notes 26-44. Appellant submits that this ingenuity is misspent. Where a statute is plain on its face, it is unnecessary, and indeed inappropriate, to delve into

legislative materials. Crooks v. Harrelson, 282 U.S. 55, 59-60 (1930); Rouse v. Cameron, 373 F.2d at 454, n. 18a.

The arguments for holding Section 562 inapplicable to 301(d) committees, based on the structure of the Act and its legislative history, were fully developed in this Court's October 10 opinion. Id. at 453-55. The Court's discussion amply documents the extent of ambiguity in the background of the statute and will not be repeated here.

The principle that statutes should be interpreted in a manner to avoid constitutional problems is well-established. Crowell v. Benson, 285 U.S. 22, 62 (1932); Benton v. Reid, 98 U.S. App. D.C. 27, 231 F.2d 780 (1956); Lynch v. Overholser, 369 U.S. 705, 710-11 (1962). As noted above, Appellee's approach, which excludes Section 301(d) patients from the protection of Section 562 and suggests that they receive less assurance of adequate treatment, would have the effect of denying Appellant the equal protection of the laws.

Moreover, in interpreting Section 562, it should be observed that the section was passed against a background of testimony urging the view that involuntary hospitalization without adequate treatment constituted a deprivation of liberty without due process. See testimony cited at n. 2,

Rouse v. Cameron, 373 F.2d 451 (1966). See also S. Rep. No. 925, 88th Cong., 2d Sess. 12. Senator Ervin, the principal architect of the bill, stated:

"The argument is valid . . . that to deprive a person of liberty on the ground that he is in need of treatment, and then to deny him that treatment, is tantamount to a denial of due process." Cong. Rec., July 6, 1964, p. 15459 (daily ed.).

Given the fact that the principal sponsor of the bill considered the right to receive adequate treatment a constitutional right, it is hard to believe that his bill recognized the right to treatment of only one group of the patients in the District's mental hospitals, but not others.

B. Section 24-301

Appellant contends that the right to receive adequate treatment is implicit in Section 24-301, dealing with commitment and release. Appellee has conceded that Congress intended 301(d) committees to receive treatment. Appellee's Brief 38, text preceding n. 37. The legislative materials reflect this intention. See, e.g., S. Rep. No. 1170, 84th Cong., 1st Sess. 13 (1955). And a long line of decisions of this Court recognizes this intention. See, e.g., Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 281 F.2d 943 (1960).

In Green v. United States, 349 F.2d 203 (1965), the Court en banc held that "a patient has a cognizable interest in securing the medical treatment which commitment is intended to assure." 121 U.S. App. D.C. 226, 228, 349 F.2d 203, 205 (1965). See also Darnell v. Cameron, 121 U.S. App. D.C. 58, 348 F.2d 64 (1965).

Thus, Section 562 simply declares and makes explicit the right of a patient committed under Section 301(d) to receive adequate and appropriate treatment, a right which was, from the passage of Section 301(d), a corollary of mandatory commitment.

IV. THE DETERMINATION OF ADEQUACY OF TREATMENT

To recapitulate the areas of agreement between Appellant and Appellee, there is no dispute that:

1. Patients committed under Section 24-301(d) have a right to some kind of psychiatric treatment, Appellee's Brief 37-38, text preceding n. 37; ^{1/} 48, text preceding n. 58;
2. Habeas corpus lies to test the manner of treatment, Appellee's Brief 48, text at n. 56-59;
3. Treatment considerations may make release appropriate under certain circumstances, even though the statutory release standard is not met.
Appellee's Brief 45, text at n. 45; 48-50, text ^{2/} between notes 56-62.

^{1/} Appellee contends that the treatment issue should be raised on habeas in conjunction with a petition claiming release on the ground of recovery. Appellee's Brief 42, text following n. 44; p. 49, text following n. 59. Ibid. But Appellee suggests no compelling reason why a patient should not be permitted to seek adequate treatment by habeas corpus at any time, subject to limitations on abuse of the writ. See Creek v. Stone, No. 20, 563, opinion filed May 1, 1967; Lake v. Cameron, 124 U.S. App. D.C. 264, 364 F.2d 657 (1966) (en banc); Benton v. Reed, 98 U.S. App. D.C. 27, 231 F.2d 780 (1956).

^{2/} Indeed, Appellee asserts that "habeas judges have been considering . . . [the treatment factor] for years" in deciding whether to grant releases. Appellee's Brief 45, text at n. 48.

The principal disagreement between Appellee's position and Appellant's relates to the standard implicit in the right to treatment. Appellee contends that the hospital must afford 301(d) patients only enough treatment "to make therapeutic confinement distinguishable from imprisonment." Appellee's Brief 44, text preceding n. 44.

Appellee's proposed standard, which he recognizes "may seem a narrow one,"^{1/} has no support in case law.^{2/}

More important, this definition of the patient's right is completely inconsistent with the purposes of mandatory commitment -- the effective treatment of the patient's mental illness. This purpose for the confinement imposes on the hospital a duty to provide appropriate and suitable treatment for the particular patient's mental illness. Plainly, treatment which is unsuitable or inappropriate does not discharge the hospital's responsibility. Confinement might be "minimally distinguishable" from imprisonment if the guard is a

^{1/} Appellant's Brief 51, text preceding n. 63.

^{2/} Contrary to Appellee's suggestion, there is nothing in Robinson v. California, 370 U.S. 660 (1962), or Driver v. Hinnant, 356 F.2d 761 (4th Cir. 1966), remotely suggesting his proposed "minimally distinguishable from imprisonment" standard. Cf. Appellee's Brief 30, text following n. 25.

psychiatrist. But the government's duty would not be discharged unless the psychiatrist undertook appropriate therapeutic activity.

Appellee also suggests as a standard that the institution's burden is only to try to help the patient to recover, Appellee's Brief 49, text preceding n. 60, no matter how ineffectual, inartful, or sporadic its efforts might be. Appellant contends that the constitutional and the statutory scheme require something more than good will. If the patient is being confined involuntarily to receive treatment, he has a right to receive treatment, not simply a right to be held by people who would like to treat him.

Appellee seeks to justify this extraordinarily crabbed definition of the patient's right to treatment on the ground that courts cannot and should not enforce a broader right to treatment. Appellee's Brief 51, text preceding n. 63. The basic arguments are (1) that courts are not competent to perform this function; (2) that standards are too ephemeral; (3) that it would take up too much of the courts' time; and

(4) that it would take up too much of the time of the Hospital staff.^{1/}

Appellant contests all of these assertions and questions their relevance to the definition of patient's rights, even if they were true.^{2/}

1. The argument that courts are not competent to pass on adequacy of treatment must be rejected. Courts are regularly in the business of taking expert testimony, resolving conflicts, and drawing conclusions from the testimony. In the insanity field, courts rely on the testimony of psychiatrists and resolve conflicts among them. Appellee himself has argued that the questions of sanity and of treatment are interrelated. Brief of Appellee, Dobson v. Cameron, No. 20,573, pp. 30-33. Hence, the treatment matter would not carry the courts into wholly unaccustomed areas.

^{1/} It should be noted that these "practical" arguments apply with equal force to the inquiries this Court has directed into the adequacy of the treatment of juveniles under Creek v. Stone, supra, and In re Elmore, supra.

^{2/} It is an extraordinary assertion that the dimensions of a constitutional and statutory right relating to personal liberty should be circumscribed by the convenience of the courts and considerations relating to the court calendar. Appellee's Brief, n. 65.

2. Workable standards of adequacy can be developed. In the malpractice field, courts appraise the adequacy of treatment given by doctors. The technique of measuring performance against the principles of the school of medicine adhered to by the practitioner would also provide a manageable standard for determining adequacy of treatment in mental hospitals. See Appellant's Brief 58-59.

The courts might well establish a presumption that the existence of a written treatment plan for a particular patient, periodically reviewed, establishes prima facie that the patient is receiving adequate treatment.

Appellant contends that the standards outlined in the Rouse decision are appropriate and should be reaffirmed by the full court.

The Court there stated that the Hospital should

"show that initial and periodic inquiries are made into the needs and conditions of the patient with a view to providing suitable treatment for him, and that the program provided is suited to his particular needs. Treatment that has therapeutic value for some may not have such value for others

"The effort should be to provide treatment which is adequate in light of present knowledge. Some measures which have therapeutic value for the particular patient may be too

insubstantial in comparison with what is available." Rouse v. Cameron, 373 F.2d 451, 456-57.

As the Court stated in Tribby, this approach to the problem does not mean that the courts "should or can decide what particular treatment this patient requires." Tribby v. Cameron, No. 20,454, decided April 14, 1967, slip opin. 3. Its function is only to decide whether "a permissible and reasonable decision" has been made by the Hospital. Ibid.^{1/}

3. The suggestion that the courts will be deluged by a flood of habeas petitions is often raised when the courts recognize a new right. In the instant case it is pure speculation. Appellee's guesses as to the probable volume of petitions raising the adequacy of treatment (Appellee's Brief 53-54, n. 65-67) is without support either in the record or in common sense. The Rouse decision came down over eight months ago and the district courts are still successfully working through their dockets. Appellee has

^{1/} Appellee cites this language from Tribby with approval. Appellee's Brief 70, n. 94. This suggests that Appellee might be willing to accept a somewhat broader judicial inquiry than his rhetoric suggests.

Appellee's footnote discussing the "twenty distinct 'systems' of group therapy" highlights the kinds of issues which courts ought not consider. Appellee's Brief n. 98.

not suggested that the district judges spend more time handling habeas petitions from St. Elizabeths since the Rouse decision.^{1/}

4. While judicial inquiry into adequacy of treatment would undoubtedly take some of the Hospital staff's time away from treatment, the burden need not be overwhelming. The hearing below, being the first hearing in which the treatment matter was considered, was undoubtedly unusually long.

After the first few hearings on treatment questions, it could be expected that they would become very much more streamlined and expeditious. If depositions had been permitted in advance of the hearing below, the hearing itself would have been greatly shortened, the number of witnesses could have been decreased, and a net saving of time for all Hospital personnel could have been effected.

^{1/} Appellee's suggestion that a great number of patients would file habeas petitions challenging the adequacy of their treatment seems doubtful, since (a) the usual remedy would probably be more treatment, not release; (b) inadequacy of treatment would be difficult to establish in most cases; (c) an assertion of inadequate treatment could prejudice a claim of restored competency. As to (c), see Rouse v. Cameron, 373 F.2d 451, 462 (1966) (dissenting opinion).

It might also be noted that improved treatment records would greatly reduce the time necessary for hearings on adequacy of treatment. In the instant case the Hospital records were silent on the treatment afforded Appellant. If a written plan had been adopted 4-1/2 years ago and reviewed periodically, this record would have virtually spoken for itself in establishing treatment, and the live testimony could have been greatly reduced.

V. THE HEARING BELOW

Appellee has invited the Court to regard the hearing below as typical of the hearings to be held on adequacy of treatment. Of course, the hearing was nothing of the kind. See Appellant's Brief 95-119. The trial judge's constant interference made it impossible to develop testimony in an orderly manner; his restrictions on expert witnesses considerably narrowed the testimony offered;^{1/} and his overt hostility made it futile even to suggest the use of innovative fact-finding techniques or novel methods of introducing expert testimony as suggested by the Court in its October 10 decision. 373 F.2d at 457. Appellant submits that subsequent hearings can be expected to be shorter and more pointed. The taking of pretrial depositions or the use of other fact-finding techniques of the kind suggested by the Court in the decision of October 10 would greatly facilitate the proceeding.

Appellee's Brief discusses some matters relating to the hearing below which require some reply:

^{1/} Appellee's statement that Appellant's counsel did not "tell Judge Holtzoff . . . the full thrust of his objection to his limitation on the number of expert witnesses," Appellee's Brief (mimeo.) 98, is being deleted from the printed Brief. Appellant's counsel informed the judge as fully as the judge would permit him to.

1. Appellant's position with respect to adequacy.

Appellee's Brief aphoristically but inaccurately characterizes the Appellant's contention with respect to the "milieu therapy" to which Appellant was exposed as follows: "the Hospital was doing the right thing in the wrong way." Appellee's Brief 79, text at n. 106. In fact, Appellant's position was that milieu therapy was among the therapies which could properly be used to treat Appellant's illness, but that Appellant was not receiving milieu therapy in John Howard Pavilion. As is discussed in Appellant's Brief, the record below amply demonstrates that the essential characteristics of a milieu therapy program were totally lacking. Appellant's Brief 69-86. Summarizing his observations, Dr. Zwerling stated that he found "no indication of a rational program of treatment afforded to Mr. Rouse." Zwerling Dep. 80.

Contrary to Appellee's suggestion, Appellant's expert witnesses were not left without objective criteria by which to appraise the adequacy of the treatment afforded to Appellant.^{1/} In fact there were a number of basic facts which

^{1/} Appellee "summarizes" Dr. Zwerling's analysis of the inadequacies of Appellant's treatment in terms of "the attitude of ward personnel, and the relationship between appellant and his ward psychiatrist." Appellee's Brief 82, text following n.110. This is a misstatement of Dr. Zwerling's views. See generally Zwerling Deposition; Appellant's Brief 69-74.

distinguished the John Howard environment from the therapeutic milieu as it is understood in the profession, most importantly, (a) the almost total lack of psychiatrists' participation in the ward milieu, and (b) the lack of an individualized treatment plan. See Appellant's Brief 69-86.

2. Burden of proof. As Appellant argued in his opening Brief, pp. 57-58, the burden of proving adequacy of treatment should be on the Hospital. Given the facts that the Hospital has all the necessary information and that the petitioner is frequently indigent, it would be incongruous to impose the burden on the petitioner. See Lake v. Cameron, 124 U.S. App. D.C. 264, ___, 364 F.2d 657, 660-61 (1966), cert. denied 382 U.S. 863; Rouse v. Cameron, 373 F.2d at 456. The fact that the burden of proof in most habeas corpus cases is placed on the petitioner is hardly dispositive, in this unique context. Cf. Bolden v. Clemmer, 111 U.S. App. D.C. 392, 298 F.2d 306 (1961); Patton v. North Carolina, 256 F. Supp. 225 (D.C.W.D.N.C. 1966).

3. The staffing of John Howard Pavilion. The basic issue in the hearing below was whether Appellant has been afforded adequate treatment. The number of staff in John Howard Pavilion and the ratio of staff to patients are of

secondary importance. Nonetheless, staff shortages are significant, since a staff which is too small is less likely to provide adequate treatment.

Appellee's Brief exhaustively discusses the numerical adequacy of the staff of John Howard Pavilion. Appellee's Brief 55-66, text between notes 69-88. The major effort is to resuscitate the Standards for Hospitals and Clinics published by the American Psychiatric Association, a publication to which Dr. Cameron plainly attached little weight.^{1/}

Appellee objects that Appellant corrected the comparisons contained in Appellee's Exhibit 3 (Appendix A) to take into account the fact that one-third of the time of the John Howard psychiatrists is spent in court. See Appellant's Brief 65-67. But the statistics accumulated and submitted to this Court by Appellee's counsel (Appellee's Brief n. 65-67) establish the disproportionate volume of litigation

^{1/} It is significant that the new APA Position Statement on the Question of Adequacy of Treatment, Appellee's Brief, Appendix C, which Dr. Cameron helped draft, does not even refer to the older Standards and their ratios.

Dr. Harry C. Solomon, then President of the American Psychiatric Association, stated that "these standards represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized." Solomon, "The American Psychiatric Association in Relation to American Psychiatry," 115 Amer. J. of Psychiatry 1, 7 (1958).

generated by John Howard patients. Appellant submits that it would be grossly misleading to compare John Howard staff-patient ratios, where the doctors are in the Hospital only two-thirds of their working week, with the APA norms which make no allowance for this unique situation.

Appellee also takes issue with Appellant's suggestion that the APA "continued treatment" category is not unlike custodial care. Appellee's Brief 59-62, n. 74-80. The argument seems to be that the category of geriatric patients has even less staff. However, a review of Respondent's Exhibit 3 reveals that geriatric and continued treatment staffing are virtually identical,^{1/} and buttresses the argument that "continued treatment" means, in effect, custodial care.^{2/}

^{1/} The doctor-patient ratio for both categories is 1:150. One registered nurse for every 20 patients is called for on geriatric service; one nurse for 40 patients on continued treatment service.

It might also be noted that the standards for private psychiatric hospitals call for much lower staff-patient ratios. For example, the prescribed ratio is one doctor for every 20 patients. And there is only one treatment category. Respondent's Exhibit 3, Standards, p. 62.

^{2/} Appellee indicates that Dr. Zwerling thought inadequacy of psychiatric staff was not significant. Appellee's Brief 63, text at n.81. This is simply untrue. Dr. Zwerling testified that the psychiatrist should be present on the ward daily (Zwerling Dep. 19); and that the psychiatrist treating Appellant was over-extended in terms of the number of patients under his care (Zwerling Dep. 85), even using the techniques of milieu therapy.

Appellee dismisses St. Elizabeths' own standards, which Dr. Cameron characterized as "a very, very conservative estimate" (1967 Hearing Tr. 14) of John Howard's staffing needs, as the pipe-dream of a perfectionist. Appellee's Brief 64-65, text following n. 86.

4. The Hospital's inadequate finances. The decision of the Court in Rouse stated, "Continuing failure to provide suitable and adequate treatment cannot be justified by lack of staff or facilities." 373 F.2d at 457. Appellant submits that this position is correct. The legislative history of Section 21-562, cited by the Court, strongly reinforces this view. Ibid.

Any other conclusions would lead to an untenable result. The right to receive adequate treatment is a right of the individual patient, with roots that are both statutory and constitutional. Such a right cannot exist at the whim of an appropriations committee. Moreover, inclusion of a financial factor in the equation would greatly complicate the determination of adequacy. Would treatment that was inadequate when judged by the standards of the profession be considered adequate simply because it was the best that the hospital could provide? Would treatment that was inadequate

in one year be adequate the next because of a decrease in a hospital's appropriations?

5. The comparison to other public mental hospitals.

Appellee goes to some lengths to demonstrate that St. Elizabeths Hospital is relatively well-staffed as compared to other public hospitals.^{1/} Appellee's Brief 63-69, text between notes 81-93. But the fact that many other hospitals are less adequately staffed than St. Elizabeths is irrelevant to the question of whether the treatment of any particular patient at St. Elizabeths is adequate. The test is whether treatment of the patient is "adequate in light of present knowledge." Rouse v. Cameron, 373 F.2d at 456. "In the opinion of the American Psychiatric Association no tax-supported hospital in the United States can be considered adequately staffed." Id. at 458, and authorities there cited.

A further objection to the comparison of St. Elizabeths' staffing with other public hospitals' is that this approach imports by the back door the measure of financial

^{1/} The source of much of this information is Kanno & Glasscote, Fifteen Indices: an aid in reviewing state and local mental health and hospital programs (1966 ed.), a volume which Judge Holtzoff "declined to view" Appellee's Brief 64, text following n.84. Appellee's counsel supplemented the book's information with his own conversation with "Dr. Glasscote's office." Id. at 59, n.73.

stringency as a defining factor for adequacy. Standards of adequacy should not be made a function of the budgetary limitations of state legislatures. By looking to the level of practice in other public mental hospitals the budgetary factor becomes determinative.

6. Right to treatment and dangerousness. Of course, the recognition of a right to treatment need not lead to a wholesale release of homicidal maniacs on the community as Appellee suggests.^{1/} In its discussion of remedies, the Court in the Rouse opinion outlined some of the factors relating to the appropriate circumstances for release. 373 F.2d at 458-59. Among them was the degree of danger the patient presented to the community. Ibid.

The courts do not overstep their bounds in considering adequacy of treatment in mental hospitals. The courts are simply serving in their historic role of conservator of individual liberty -- and, in our constitutional system, assuring that no individual is deprived of his liberty in violation of statutory and constitutional rights. Indeed, the courts have a special obligation in this field since they

^{1/} Cf. Appellee's Brief 44, text at n.46. "Not even Rouse I could convince a District judge to release a sexual psychopath" who had repeatedly sexually molested small children.

actively participate in the procedure of commitment. If courts are going to continue to acquit the insane of their offenses and commit them to facilities for treatment, the courts must assure themselves that treatment is actually being provided.^{1/}

^{1/} In its gloomy predictions as to the burden on St. Elizabeths' staff, the Hospital argued that additional psychiatrists would have to be employed at John Howard Pavilion if a right to treatment were recognized. Appellee states: "That would be judicial interference with the executive with a vengeance." Appellee's Brief 55, text preceding n.69. On the contrary, it would simply be a necessary result of the courts' responsibly recognizing the statutory and constitutional rights of mental patients. Judicial decisions frequently have an impact on the operations of the other branches of government.

VI. APPELLANT'S ORIGINAL COMMITMENT PROCEEDING DEPRIVED HIM OF HIS CONSTITUTIONAL RIGHTS.

A. The Facts of the 1962 Hearing

In his opening brief, Appellant presented substantial arguments that the 1962 proceeding which led to his commitment to St. Elizabeths was in its essence unfair. The undisputed facts are shocking: Appellant did not have an opportunity to consult with counsel prior to his hearing; his counsel and his mother concluded that Appellant needed psychiatric treatment and, for that reason, interposed an insanity defense; Appellant took the witness stand and stated that he wanted to face the charges against him on the merits; without consultation, Appellant's counsel waived hearing on a meritorious motion to suppress the evidence against Appellant.

Appellee scarcely responds to these facts. Appellee's argument is directed to establishing that Appellant has not raised his points properly. Moreover, his procedural arguments, intended to convince this Court to avoid the merits of Appellant's position, are insubstantial.^{1/} It must be

^{1/} Appellant need not make these arguments in the sentencing court before bringing habeas corpus. Hill v. U.S., 206 F.2d 204 (6th Cir. 1953), cert. denied 346 U.S. (continued on following page)

reiterated that none of the facts pertaining to this issue are in dispute, and Appellee made no effort to controvert any of them. Appellant's testimony in the hearing below only reaffirmed the facts contained in the transcript and papers of the 1962 hearing.

In his only effort to meet the merits of Appellant's contention, Appellee makes the startling suggestion that an attorney for a criminal defendant can, for what he considers therapeutic reasons, undertake a course of action designed to assure commitment of his client to a mental hospital and waive any efforts to obtain an acquittal. Under the authorities cited in Appellant's opening brief, pp. 30-35, an attorney has no such authority to choose to frame his course on his personal view of his client's mental health. He is not privileged, as Appellee suggests, to avoid seeking an acquittal lest it effect a "reinforcement of the symptom-

(continued from preceding page)

859; cf. Ingols v. District of Columbia, 103 A.2d 879 (D.C. Mun. App. 1954); Pollen v. Preston, No. 19,350, decided October 7, 1965, the unreported Order of this Court on which Appellee relies, is inapposite. Moreover, Appellee's arguments that habeas corpus is barred by laches and by Appellant's failure to appeal the original finding of not guilty by reason of insanity are equally frivolous.

pattern of his [client's] illness" Appellee's Brief 108, text at n. 135.

Appellee insinuates that Mr. Laughlin sought his client's commitment to St. Elizabeths in order to "moot out felony prosecutions in another jurisdiction where insanity acquittals are not so easily achieved," p. 109, text preceding n. 135, and "to keep appellant out of jail on other charges" Ibid. This innuendo is absolutely without basis in the record. Mr. Laughlin stated on the record that he was waiving Appellant's defense on the merits because he thought Appellant needed treatment. 1962 Trial Tr. 22. And Appellant himself testified that he wanted to clear up the matter in the District, and face the pending charges. Id. at 211.^{1/}

B. Section 301(d) Is Unconstitutional on Its Face.

Appellee devotes only two and one-half pages to this most substantial question, suggesting that "it might well be presumptuous of this Court to review it yet again."

^{1/} The theory which Appellant baselessly projects into Mr. Laughlin's mind -- that a commitment to St. Elizabeths can be expected to "moot out" felony prosecutions in another jurisdiction -- is quite novel.

Appellee's Brief 105, text following n. 131. Appellant submits that it was not presumptuous and urges the Court ^{1/} to reconsider the constitutionality of the section.

On March 10, 1967, Judge Halleck of the Court of General Sessions held that supervening judicial decisions and statutes required reconsideration of this Court's decision in Ragsdale v. Overholser, supra. He held § 24-301(d) unconstitutional. The government sought review of this determination by a Writ of Mandamus in the District of Columbia Court of Appeals. By Order of June 15, 1967, that Court denied the government's petition. (Order attached)

Section 301(d) commitment rests on a "presumption of continuing insanity" to establish the requisite present insanity and dangerousness which justify commitment. S. Rep. No. 1170, 84th Cong., 1st Sess. 13 (1955); Appellee's Brief 90, text at n. 124. In his opening brief, Appellant argued that the presumption was too weak a reed on which to rest commitment for an indefinite period. Appellant's Brief 42-47. The recent decision of the Supreme Court in Specht

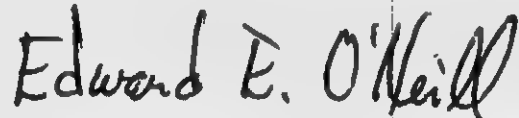
^{1/} Appellee mischaracterizes the decision of the Supreme Court in Lynch v. Overholser. Resting its interpretation of the statute, the Court explicitly stated that it was not passing on the constitutionality of § 301(d). 369 U.S. at 709-10. The Court did not hold that the statute "was free from all but 'insubstantial constitutional doubts,'" Appellee's Brief 105, IVC.

v. Patterson, 35 U.S.L.Wk. 4340 (1967), buttresses this argument. In Specht the Court held that a due process hearing had to be held after conviction, to establish the necessary additional facts which would justify sentencing a defendant as a sex offender. By the same reasoning, a defendant found not guilty by reason of insanity would be entitled to a due process hearing to determine the additional facts -- present mental illness and dangerousness -- which justify his commitment. A mere presumption will not suffice as a basis for incarceration for an indefinite term.

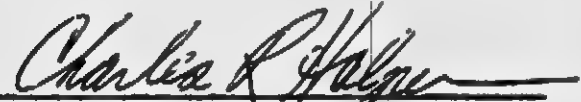
CONCLUSION

Appellant requests this Court to grant him the relief requested on page 120 of his opening brief.

Respectfully submitted,



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Court of Appeals

FILED JUN 15 1967

C. Newell Atkinson

CLERK

67

JANUARY TERM, 19

No. 3480 Original
In the matter of

CHARLES W. HALLECK,
Associate Judge, District of
Columbia Court of General Sessions

O R D E R

Tried by the court on a charge of assault, Arduini was found not guilty by reason of insanity. The trial judge refused to commit Arduini to a hospital for the mentally ill under D. C. Code 1961, § 24-301(d). The government has petitioned for a writ of mandamus to compel such commitment by the trial judge. Arduini, intervening, opposes issuance of the writ, but his grounds for opposition differ from those advanced by the trial judge. All parties filed briefs and oral argument was had.

Mandamus is an extraordinary writ and cannot be used as a substitute for an appeal. The writ will issue to compel a judge to take action only when the duty of the judge to so act is clear and free from doubt.

The government insists that the statute above cited clearly establishes the duty of the trial judge to order the commitment. This contention is necessarily based on the premise that Arduini asserted or invoked insanity as a defense, for *Lynch v. Overholser*, 369 U.S. 705 (1962), holds that mandatory commitment is not authorized when the accused disclaims reliance on a defense of mental incapability. See

also Cameron v. Mullen, _____ U.S.App.D.C. _____,
_____ F.2d _____ (decided March 2, 1967).

The trial judge was of the opinion that Arduini relied in an affirmative way on a claim of mental irresponsibility. Arduini contends that he expressly disclaimed reliance on insanity as a defense and that the issue was injected in the case by the trial judge. The conclusion of the judge and the contention of Arduini are both supported to some degree by the record. It is not clear and beyond doubt which one is factually and legally correct. Consequently the duty of the trial court to order commitment is not clear and beyond doubt.

It is the opinion of this court that this case is not one which justifies the issuance of a writ of mandamus. We do not reach or decide any other question raised by either the trial judge or by Arduini.

Wherefore, it is ordered:

1. That the petition for writ of mandamus be denied.
2. That the order of this court of March 10, 1967, be vacated.

For Curiam.

June 15, 1967

Copies to:

Honorable Charles W. Halleck
Judge, D. C. Court of General Sessions.

Clerk, D. C. Court of General Sessions.

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Certificate of Service

I hereby certify that a copy of the foregoing brief has been hand-delivered to Thomas Lombard, Assistant United States Attorney, United States Courthouse, Constitution Avenue and John Marshall Place, Washington, D.C., this 19th day of June, 1967.

A handwritten signature in cursive script, reading "Charles R. Halpern", written over a horizontal line.

Charles R. Halpern
Attorney for Appellant

En Banc
6/21/67

CONSOLIDATED BRIEF FOR APPELLANT

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20,881
No. 20,962

Charles C. Rouse,

Appellant,

v.

Dale C. Cameron, Superintendent,
St. Elizabeths Hospital,

Appellee.

Appeals from the United States District Court
for the District of Columbia

United States Court of Appeals
for the District of Columbia Circuit

FILED MAY 19 1967

Nathan J. Paulson
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STATEMENT OF QUESTIONS PRESENTED

I. Whether Appellant was properly committed to St. Elizabeths Hospital pursuant to D. C. Code § 24-301(d) when the record establishes that he did not rely on the sanity defense.

II. Whether Appellant was denied the effective assistance of counsel when, without consultation, his counsel waived Appellant's rights to a defense on the merits and acquiesced in the government's interposition of the sanity defense.

III. Whether, on the record below, Appellant can be deemed to have waived his right to defend on the merits and put the government to its proof.

IV. Whether commitment under Section 24-301(d) of Appellant deprived him of liberty without due process and violated his right to the equal protection of the laws.

V. Whether, assuming Section 24-301(d) is constitutional, the burden of proving a petitioner's present insanity and dangerousness in a habeas corpus proceeding should be on the government where the petitioner has been committed under Section 24-301(d).

VI. Whether the district court erred in holding that the burden of proof of inadequacy of treatment was on Appellant.

VII. Whether the district court erred in applying an erroneous standard to determine adequacy of treatment.

VIII. Whether the record establishes that Appellant was not receiving adequate treatment in St. Elizabeths Hospital.

IX. Whether, on the record, Appellant is entitled to a conditional release.

X. Whether, because of the district court's erroneous rulings of law and its arbitrary conduct of the remand hearing, Appellant was denied a fair opportunity to present his position on adequacy of treatment.

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JURISDICTIONAL STATEMENT

These are appeals of two orders of the U.S. District Court for the District of Columbia denying the relief requested by Appellant in his petitions for writs of habeas corpus, and remanding Appellant to the custody of Appellee. The District Court had jurisdiction under D.C. Code § 16-1901 (1961, Supp. V). This Court has jurisdiction of these appeals under 28 U.S.C. § 1291.

Statement of the Case

Appellant, now twenty-two years old, has been confined in St. Elizabeths Hospital for the past four and one-half years. He was found not guilty by reason of insanity on a misdemeanor charge carrying a maximum term of imprisonment of one year. ^{*/}

I. THE LEGALITY OF APPELLANT'S COMMITMENT - NO. 20,962

On April 11, 1967 Appellant filed a petition for writ of habeas corpus, H.C. No. 179-67, challenging the legality of his original commitment. The writ issued, and a hearing was held on April 24, 1967. At the hearing the following facts were developed through exhibits and the oral testimony of Appellant.

*/ Reference will be made throughout this brief to four lower court proceedings: (1) Appellant's original trial in the Municipal Court, Crim. No. U.S. 5962-62, November 9, 1962, will be referred to as "1962 Trial." (2) The first hearing on Appellant's petition for writ of habeas corpus, H.C. No. 287-65, held on September 13, 1965, and November 1, 1965, will be referred to as "1965 Hearing." (3) The hearing on remand from the decision of this Court in Rouse v. Cameron, No. 19,863, decided October 10, 1966, as amended, April 4, 1967, which was held on January 9, 12, 16, and 17, will be referred to as the "1967 Hearing." (4) The hearing on Appellant's petition for writ of habeas corpus, H.C. No. 179-67, held on April 24, 1967, will be referred to as "1967 Hearing-New Writ."

*/
The Arrest and Search

On September 7, 1962, at approximately 1:45 A.M.; Private Otis D. Bruce of the District of Columbia Police Department saw Appellant come out of an apartment house on Fifteenth Street "carrying a suitcase, which seemed to be rather heavy to be carrying -- to be such a small suitcase." 1962 Trial, Tr. 3. Private Bruce followed him for a block, stopped him, Ibid., and ordered him to open his suitcase. 1962 Trial Tr. 20; H.C. No. 179-67, Exhibit C, ¶ 3. Appellant was charged with the unlawful possession of the pistol which this search revealed.

Appellant was charged under D. C. Code § 22-3204 (1961 ed.) with possession of a pistol without a license. The maximum penalty for the offense is imprisonment for

*/ The facts set forth herein under these sections are based on the transcript of the 1962 trial which was prepared on March 13, 1967 at the request of Appellant's counsel and on inquiries subsequently undertaken by counsel. Prior to that time counsel had been informed that no reporter had been present at the 1962 trial. Appellant did not know prior to that time that a reporter had been present and did not know the legal significance of the facts set forth herein. Rouse v. Cameron, H.C. 179-67 [hereinafter cited as H.C. 179-67], Exhibits C and D; see also 1965 Hearing Tr. 48-49.

one year or a \$1,000 fine, or both. D.C. Code § 22-3215 (1961 ed.). Appellant, who was then eighteen years old, had not theretofore been convicted of any offense in the District of Columbia or elsewhere.

The 1962 Trial

Samuel J. Ochipinti was assigned to represent Appellant in the Municipal Court of the District of Columbia, (now the Court of General Sessions). H.C. 179-67, Exhibit E, ¶ 2. After consultation with Appellant, he promptly filed a motion to suppress the evidence seized from Appellant. H.C. 179-67, Exhibit B, Motion of September 15, 1962. He and his client concluded that this Motion was the primary line of defense to be followed in the case. 1967 Hearing-New Writ 4-5. Shortly thereafter, Appellant's mother retained James J. Laughlin to represent Appellant and dismissed Mr. Ochipinti. H.C. 179-67, Exhibit E, ¶ 4. At his trial Appellant testified that he thought Mr. Ochipinti was doing a good job and that he agreed with the strategy he had adopted. 1962 Trial Tr. 20.

Mr. Laughlin decided, without consulting Appellant or discussing the matter with him, to waive a hearing on the Motion to Suppress. 1962 Trial Tr. 20, 22; H.C. 179-67, Exhibit C, ¶ 4.

On motion of Mr. Laughlin, Appellant was sent to the District of Columbia General Hospital for a mental examination. The Hospital reported that Appellant was "of sound mind, able to understand the charges against him, and capable of assisting counsel in his own defense." H.C. 179-67, Exhibit B, Letter of October 24, 1962. There was no suggestion at the trial that Appellant was not fully competent, and his testimony at the trial was forceful and coherent. 1962 Trial Tr. 18-23.

At the trial, the Government called Dr. James A. Ryan, a psychiatrist from the District of Columbia General Hospital, who testified that Appellant's criminal conduct was the product of a mental illness. 1962 Trial Tr. 9-12. Appellant's counsel did not put on any testimony to contradict the Government's showing that Appellant's conduct was the product of a mental illness.

At the end of the hearing, the defendant was, for the first time, given an opportunity to be heard. In his testimony, he stated that he had not been consulted on the introduction of the insanity issue, that he opposed the interposition of the insanity defense, that he thought his Motion to Suppress was meritorious, and that he wanted the case tried on the merits. 1962 Transcript, pp. 19-21. The sum of his testimony -- in his own words -- was: "I feel that I've been lured right into this thing" 1962 Trial Tr. 21.

The record clearly establishes that Appellant wanted a hearing on his Motion to Suppress. Yet Appellant's desire to have a hearing and decision on his Motion to Suppress was outweighed by a consensus which was defined in Mr. Laughlin's words: "Our belief -- the belief of the mother and my belief and Mr. Daly's [an Assistant United States Attorney] belief -- is that this man needs treatment." 1962 Trial Tr. 22.

Following the finding of the trial judge that Appellant was not guilty of the offense charged by reason of insanity, Appellant was committed to St. Elizabeths Hospital

H.C. No. 179-67, Exhibit B, Order of November 9, 1962. He was placed in John Howard Pavilion, the Hospital's maximum security service. Appellant resides in John Howard Pavilion at the present time.

The Decision on the New Writ

The government did not put on any testimony or controvert any of the facts established by Appellant.

The court dismissed the writ from the Bench and filed an Order and Findings of Fact and Conclusions of Law with its Order on May 2, 1967. Appellant filed a Notice of Appeal the same day and, subsequently moved this Court for consolidation of this appeal (No. 20,962) with his pending appeal, No. 20,881. Appellant's motion was granted by Order of May 11, 1967.

II. POST-COMMITMENT ISSUES - RESTORED SANITY AND TREATMENT - NO. 20,881

The treatment afforded Appellant during the 4-1/2 years he has been in St. Elizabeths is one of the central issues in this appeal and it is discussed at length below (pp. 58-66). Hence this statement is limited to a brief description of the legal proceedings involving Appellant

since his commitment.

The 1964 Hearing

On June 22, 1964 a hearing was held before Judge Hart on Appellant's petition for a writ of habeas corpus. H.C. No. 232-64. Dr. Agler, his ward administrator at that time, testified that Appellant might make a favorable adjustment if he had psychotherapy on a regular basis and developed a strong working relationship with his therapist. 1967 Hearing, Petitioner's Exhibits 1 and 2, Psychiatric Notes [hereinafter cited as "Psychiatric Notes"], June 22, 1964.

Dr. Agler noted that a question was raised at the hearing about the fact that Appellant had been committed to the Hospital despite his unwillingness to rely on the insanity defense, because his mother thought he needed treatment. Ibid. No disposition was made of this point.

Dr. Agler stated that Judge Hart had thought the petition had merit, but delayed granting it "to allow the hospital time to set conditions for a conditional release with the family." Ibid.

At that time Appellant had been in the Hospital for a year and a half. Dr. Straty Economon, Appellant's present ward administrator, replaced Dr. Agler shortly after the hearing before Judge Hart. Dr. Economon stated that Appellant "must seek ways of learning adaptive behavior in the ward community." Psychiatric Notes, August 12, 1964. Almost three years have elapsed since that note was written.

The 1965 Hearing

In 1965, Appellant filed another petition for a writ of habeas corpus. H.C. No. 287-65. In that proceeding Appellant alleged that he had recovered his sanity and that he was entitled to his release because he had not received adequate treatment in the three years he had been detained in the Hospital. Judge Holtzoff refused to hear argument on the adequacy of treatment on the ground that it was not a justiciable issue.

Dr. Economon testified that Appellant was still suffering from a mental illness and would be dangerous if released. Dr. Albert Marland, a witness for Appellant, testified that Appellant should be given a conditional release. He specifically stated that there was little risk

that Appellant would commit any act of violence if released. He referred to his possession of a gun as "a solitary incident, out of context with every other problem he has had." 1965 Hearing Tr. 53-54.

Judge Holtzoff was sufficiently concerned about the case that he took the unusual step of continuing the hearing and referring the matter to the Mental Health Commission for an advisory opinion. Id. at 81-84. The Mental Health Commission reported:

"It is the considered opinion of the Commission, after examination of Charles C. Rouse, that he has recovered from the mental illness for which he was committed in 1963 and is not mentally ill at this time. For the past 18 months he has exhibited no anti-social behavior, confusion, or grandiose ideas. He is aloof from most other patients, but during his stay in the hospital he has had several buddies. He tends to choose an environment that provides no social conflict for him.

"It is the opinion of the Commission on Mental Health that further hospitalization of this man will stifle his future development and that he should be discharged. He has arrangements to see a psychiatrist upon discharge to aid in his rehabilitation."

Dr. Clarence Bunge, a member of the Mental Health Commission, testified that Appellant would not be dangerous

to himself or others if released.

After hearing all testimony, the judge ruled that Appellant was not yet restored to sanity, placing heavy reliance on the fact that the original offense for which Appellant had originally been tried had involved a gun. Appellant appealed from the district court's decision.

The Decision of the Court of Appeals

This Court reversed the district court's dismissal of Appellant's writ. Rouse v. Cameron, No. 19,863, October 10, 1966, as amended April 4, 1967. The Court remanded the case for a thorough hearing on the adequacy of the treatment afforded to Appellant. The opinion invited a wide-ranging inquiry into standards of mental care, Slip opin., p. 10, with specific reference to the appropriateness of the treatment afforded Appellant for his particular needs. Id. at 8-9. The opinion also instructed the district court to reconsider its finding on Appellant's present mental condition.

The Proceedings on Remand

In order to be able to prepare fully for the remand hearing, counsel for Appellant filed a Notice of Deposition

on November 30, 1966. The government moved to quash the Notice, and a hearing was held before Judge Holtzoff on the matter. Appellant submitted affidavits of counsel and two expert psychiatrists stating that the information which could be obtained by deposition was necessary to the adequate preparation of Appellant's case. The judge sustained the government's motion to quash.

Appellant then came to this Court for clarification of its remand order. This Court, while noting the possibility that denial of depositions might substantially prejudice Appellant, denied the extraordinary relief requested by per curiam order (one judge noting his dissent). The order stated that the denial of depositions could be raised on appeal from the remand proceeding.

The remand hearing began on January 9, 1967, and, after hearings on four days, terminated on January 17, 1967. Appellant will argue that the evidence adduced at the hearing compels the conclusion that Appellant did not receive adequate treatment (infra, pp. 68-86) and that the conduct of the trial judge denied Appellant a fair hearing (infra, pp. 102-19). Therefore, Appellant

will not at the present time detail the testimony at the hearing.

The evidence included testimony in open court, depositions of two expert witnesses offered by Appellant, the records kept by the Hospital detailing the treatment afforded Appellant, the transcript of the 1965 Hearing, and various exhibits introduced in evidence by the government.

At the end of the hearing, Judge Holtzoff ruled from the bench that Appellant had not proved that he was restored to sanity and no longer dangerous to himself or others. He further held that the treatment afforded to Appellant was adequate.

In No. 20,881, Appellant appeals from the decision of Judge Holtzoff in the remand hearing in H.C. No. 287-65.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

I. THE CONSTITUTION OF THE UNITED STATES

A. Fifth Amendment:

"No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation."

II. STATUTES

A. Title 24, Section 301(d), District of Columbia Code (1961), provides:

"If any person tried upon an indictment or information for an offense, or tried in the juvenile court of the District of Columbia for an offense, is acquitted solely on the ground that he was insane at the time of its commission, the court shall order such person to be confined in a hospital for the mentally ill."

B. Title 21, Section 562, District of Columbia Code (1961, Supp. V), provides:

"A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and

psychiatric care and treatment. The administrator of each public hospital shall keep records detailing all medical and psychiatric care and treatment received by a person hospitalized for a mental illness and the records shall be made available, upon that person's written authorization, to his attorney or personal physician. The records shall be preserved by the administrator until the person has been discharged from the hospital."

STATEMENT OF POINTS

- I. Appellant was improperly committed to St. Elizabeths Hospital under Section 24-301(d) because he did not rely on the insanity defense.
- II. Appellant was denied the effective assistance of counsel, which rendered his original trial patently unfair.
- III. Appellant was unfairly deprived of an opportunity to contest the case against him on the merits and to have a hearing on his Motion to Suppress.
- IV. Section 24-301(d) is unconstitutional on its face and as applied to Appellant.
- V. Assuming that Section 24-301(d) is not unconstitutional, the District Court erred in imposing on Appellant the burden of establishing present insanity.
- VI. The District Court erred in imposing on Appellant the burden of showing the inadequacy of treatment in St. Elizabeths Hospital.
- VII. The District Court erred in applying an erroneous standard to determine adequacy of treatment.

VIII. The record establishes that Appellant was not receiving adequate treatment in St. Elizabeths Hospital.

IX. On the record, in view of the inadequacy of treatment and other factors, Appellant is entitled to a conditional release.

X. In the remand hearing on adequacy of treatment, Appellant was denied a fair opportunity to develop his position because of the district judge's erroneous rulings of law and his arbitrary handling of the proceedings.

SUMMARY OF ARGUMENT

I. Appellant contends that his initial commitment under § 24-301(d) was invalid. The undisputed record before this Court plainly establishes that Appellant did not rely on the insanity defense in his original trial in the Court of General Sessions. His attorney, who acquiesced in the introduction of the issue by the government, acted without consulting Appellant and in opposition to Appellant's desires stated in open court. Therefore, Appellant could not properly be committed under D.C. Code § 24-301(d). Lynch v. Overholser, 369 U.S. 705 (1962); Cameron v. Mullen No. 20,308, decided March 2, 1965 (D.C.Cir.).

Appellant was denied a fair hearing because his trial counsel did not afford him effective representation. On advice of assigned counsel, Appellant had filed in advance of trial a motion to suppress the evidence against him; the record reveals that his motion had substantial merit. Cf. Kelley v. United States, 111 U.S. App. D.C. 396, 298 F.2d 310 (1961). Without consulting Appellant, trial counsel, James J. Laughlin, waived a hearing on Appellant's motion to suppress the evidence

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Appellant was denied a fair hearing because his trial counsel did not afford him effective representation. On advice of assigned counsel, Appellant had filed in advance of trial a motion to suppress the evidence against him; the record reveals that his motion had substantial merit. Cf. Kelley v. United States, 111 U.S. App. D.C. 396, 298 F.2d 310 (1961). Without consulting Appellant, trial counsel, James J. Laughlin, waived a hearing on Appellant's motion to suppress the evidence

against him, and, in effect, waived Appellant's right to contest the case on the merits. Such actions were not justified by any tactical considerations; counsel stated that he did so because he thought that Appellant needed treatment. Appellant was denied the effective assistance of counsel. Mitchell v. United States, 104 U.S. App. D.C. 57, 259 F.2d 787 (1958), cert. denied, 358 U.S. 850. And he cannot be thought to have knowingly waived his right to have the case tried on the merits. Cf. Brookhart v. Janis, 384 U.S. 1 (1966).

II. If the above contentions are rejected, Appellant urges that this Court hold § 24-301(d) unconstitutional on its face and as applied to Appellant. Mandatory commitment under this section, which provides the committee far less procedural protection than civil commitment under D.C. Code §§ 21-541 through 21-546 (1961 ed., Supp. V), deprives petitioner of the equal protection of the laws. Baxstrom v. Herold, 383 U.S. 107 (1966); Cameron v. Mullen, supra. No legitimate classification justifies these disparities in procedure.

Commitment of a person for an indefinite period on a jury finding of reasonable doubt as to his sanity at a time in

the past, with no finding as to present mental condition or dangerousness, deprives the committee of due process of law. The justifications for involuntary commitment of the mentally ill are the need for treatment and the need to protect the individual and society. These purposes do not bear any rational relation to a finding of reasonable doubt as to sanity at a time in the past. Even if the statute is not held to violate due process on its face, the continued detention of Appellant, 4-1/2 years after being found not guilty of a misdemeanor, deprives him of his liberty without due process. Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 315-16 (1960).

The mandatory commitment section imposes an unconstitutional burden on the exercise of a constitutionally protected right. Cf. Griffin v. California, 380 U.S. 609 (1965).

If the above constitutional arguments are rejected, the reasoning of the Baxstrom and Mullen decisions dictate, at the very least, that the burden of proof in a habeas corpus proceeding brought by a person committed under § 24-301(d) should be on the government to establish that the petitioner is mentally ill and dangerous. The record reveals that the government did not bear its burden in these respects in the instant case.

III. Appellant contends that the evidence on treatment adduced at the remand hearing in H.C. 287-65 compels the conclusion that Appellant has not had adequate treatment in St. Elizabeths Hospital.

The burden of proving adequacy of treatment should be on the government, once the petitioner has made a prima facie showing of inadequacy. Cf. Lake v. Cameron, ____ U.S. App. D.C. ____, 364 F.2d 905 (1966), cert. denied, 382 U.S. 863. The proper standard in determining the adequacy of treatment is whether the treatment afforded is "adequate in light of present knowledge." The test is not whether the treatment is comparable to the treatment afforded in other public mental hospitals or whether it is the best treatment which the treating hospital can afford within budgetary limitations. Rouse v. Cameron, Slip opin., p. 9. The district court erred as to the burden of proof and to the standard of adequacy to be applied.

The evidence established that milieu therapy was the basic treatment afforded to Appellant. Dr. Cameron's testimony established that the staffing of John Howard Pavilion, the maximum security service in which Appellant resided, was substantially inadequate. Other expert testimony

established that the treatment afforded Appellant was substantially inadequate and differed in essential respects from milieu therapy as the term is understood within the profession. Given the inadequacy of the treatment afforded to Appellant, Appellant is entitled to a conditional release under the criteria set down by this Court in its remand decision. Slip opin., p. 13. In the event that the Court holds that treatment was inadequate but Appellant is not entitled to immediate release, Appellant requests this Court to order Appellant released if the Hospital does not promptly develop an adequate treatment program for Appellant.

If the Court does not accept Appellant's contention that the evidence established the inadequacy of treatment or Appellant's other arguments set forth above, Appellant requests the Court to remand the case for a new hearing on the adequacy of treatment. The district judge erred in denying Appellant an opportunity to take the depositions of Hospital staff, an error which severely prejudiced Appellant in the hearing. In addition, he made other erroneous rulings on matters of law and, in the course of the hearing, his hostile attitude and apparent unwillingness to comply with this Court's remand order unreasonably hampered Appellant's efforts to establish his case for inadequacy of treatment.

ARGUMENT

I. APPELLANT'S COMMITMENT TO ST. ELIZABETHS HOSPITAL IS NOT AUTHORIZED BY THE MANDATORY COMMITMENT STATUTE AND DEPRIVES HIM OF HIS CONSTITUTIONAL RIGHTS

A. Since Appellant Objected to the Interposition of the Insanity Defense at His Trial, He Could Not Be Mandatorily Committed Under D. C. Code § 24-301(d)

On November 9, 1962, Appellant was tried in the Court of General Sessions on a charge of unlawful possession of a pistol. Upon a finding that he was not guilty by reason of insanity, the trial judge, without further proceedings, committed him to St. Elizabeths. Appellant contends that the Court exceeded its statutory authority in issuing this order.

Less than six months before Appellant's trial, the Supreme Court decided Lynch v. Overholser, 369 U.S. 705 (1962). In that case the Court construed the mandatory commitment section, D.C. Code § 24-301(d):

"If any person tried upon an indictment or information for an offense, or tried in the juvenile court of the District of Columbia for an offense, is acquitted solely on the ground that he was insane at the time of its commission, the court shall order such person to be confined in a hospital for the mentally ill."

In order to avoid "not insubstantial constitutional doubts," 369 U.S. at 711, the Court held that this section applies only to a defendant "who has affirmatively relied on a defense of insanity" 369 U.S. at 710.

At the time of the trial, Appellant believed that he had a meritorious argument for the suppression of the evidence against him. He had been so informed by his assigned attorney, Mr. Ochipinti, and he did not want to introduce the insanity defense.

Prior to trial, Appellant's mother dismissed Mr. Ochipinti and retained James J. Laughlin to represent Appellant. 1967 Hearing-New Writ Tr. 5. His mother and Mr. Laughlin agreed, without consulting Appellant, to move for a mental examination. Id. at 5-6; H.C. 179-67, Exhibit B, Motion for Mental Examination, Affidavit of September 19, 1962.

Appellant was found to be "of sound mind, able to understand the charges against him, and capable of assisting counsel in his own defense." H.C. 179-67, Exhibit B, Letter

of October 24, 1962.^{*/} Nonetheless, Mr. Laughlin took it upon himself, without consulting Appellant, to acquiesce in the government's introduction of the insanity issue.

Appellant's attorney announced to the court that he "took it upon [him]self to waive any hearing on the motion to suppress" because of his agreement with Appellant's mother that Appellant needed treatment. 1962 Trial Tr. 22. The undisputed evidence reflects that Appellant never discussed the waiver of the Motion to Suppress or the introduction of the insanity defense with his trial counsel, Mr. Laughlin. Appellant's mother and Mr. Laughlin had agreed on this strategy without consulting Appellant.

At the end of the hearing, after all other testimony was in, Appellant was given an opportunity to be heard. In his testimony he clearly indicated that he had not been a party to the decision to raise the insanity defense and

^{*/} There is no suggestion that his mental processes were in 1962, or at any other time, so impaired that he could not give meaningful assistance to his counsel or determine in which direction his best interests lay. Indeed, his testimony at the trial was cogent and pointed. Appellant has at no time been delusional or hallucinatory. 1962 Trial Tr. 18-21.

that he objected to its interposition. He repeated his reliance on the Motion to Suppress:

A. I had just one thing to say, Mr. Laughlin. I believe the doctor did say I was able to aid in my own defense and I have not had a chance to talk to Mr. Laughlin, consult him since he's been my attorney. I had Mr. Ochipinti, who was doing a fairly good job with me; at least, discussing what he was going to do. I have not talked with Mr. Laughlin; or my mother about this case. I have no idea what they were going to do in court or anything else, and I think I would have the right to defend myself and, as it was, so far I haven't been able to say a word up until now.

Q. Mr. Defendant, do you feel the situation would have been different here had you talked with me, sir? Would it have changed anything here had you talked with me?

A. Well, I think, in the first place, I had a motion in for illegal search and seizure which I wasn't given a chance to present to the Court. I don't know what happened to my other attorney, Mr. Ochipinti. Either my mother or you did something -- one of you; I don't know which one of you. But, anyway, as I was picked up, they did not have a warrant for me, search or arrest, which they did, and the gun was in a suitcase, a closed suitcase. The police picked me up. They told me to open the suitcase. This policeman -- I had not been doing anything suspicious, anything that would cause him to arrest me. And, therefore, I believe this constitutes illegal search and seizure and, also, would require a suppression of the evidence since the evidence obtained was by the manner of an illegal search.

1962 Trial Tr. 19-21.

Under the cross-examination of his own counsel, he conceded that he felt a need for psychiatric treatment; but he insisted that he wanted to "clear this matter up here, now" 1962 Trial, p. 21.

On the facts of this case, it is plainly impossible to conclude that Appellant, in the language of Lynch, "affirmatively relied on a defense of insanity." He made it as clear as any defendant could be expected to that he did not want to rely on an insanity defense. It would be unreasonable to expect an 18 year old, who was, in effect, without legal advice in the trial, to protest more strenuously than Appellant did against his own counsel's actions. Appellant gave a clear explanation of the legal theory behind his motion to suppress the fruits of a search that was, at best, highly suspect. Cf. Gatlin v. U.S., 117 U.S. App. D.C. 123, 326 F.2d 666 (1963); Kelley v. U.S., 111 U.S. App. D.C. 396, 298 F.2d 310 (1961). He stated that he wanted a hearing on his motion to suppress; but his views were outweighed by his counsel's and his mother's belief that he needed treatment.

Under these circumstances, it would be farcical to transmute counsel's acquiescence in the introduction of the insanity defense by the government into reliance on the defense by Appellant.^{*/}

The policy of the Lynch case -- a concern "for safeguarding those suspected of mental incapacity against improvident confinement," 369 U.S. at 711 -- has recently been reiterated by this Court in Cameron v. Mullen, ___ U.S. App. D.C. ___, ___ F.2d ___, No. 20,308, March 2, 1967. In Mullen, this Court dealt with the habeas corpus petition of a defendant who, like Appellant, was found not

^{*/} In the court below counsel for Appellee suggested that Appellant is somehow estopped by the fact that he has not raised this matter sooner. However, the record in this case clearly establishes that Appellant had no knowledge of the legal significance of the facts set forth above. His failure to seek relief on the basis of an unknown legal theory can hardly support the inference that he acquiesced in his illegal confinement. Furthermore, the Appellee has not suggested that it has been prejudiced in any way by the delay in the airing of this issue. Government counsel at the trial was apparently aware of the Lynch problem as shown by his request, after the government psychiatrist's testimony, that "the records reflect that this is on the defense motion for mental observation." 1962 Trial Tr. 15. However, a motion for a mental examination, in any case, would not constitute introduction or reliance on the insanity defense.

guilty by reason of insanity, despite the fact that she did not herself interpose the insanity defense. The Court held that civil commitment was the only procedure by which such a person could be committed to St. Elizabeths Hospital. The logic of Lynch and Mullen compels the conclusion that Appellant could not properly be committed to St. Elizabeths Hospital unless he could be committed in a civil commitment proceeding.

B. Appellant Was Denied A Fair Hearing Because
He Was Not Represented by Counsel Dedicated
to His Interests

1. Counsel Rendered Ineffective Assistance
by Virtue of the Fact That He Did Not
Serve Appellant's Interests

The uncontradicted record plainly reflects that Mr. Laughlin, who had been retained by Appellant's mother, was not serving Appellant's interest. The undisputed facts are that counsel did not once discuss with his client the major strategy to be adopted in the case, and, in fact, acted against Appellant's wishes and interests. When Appellant took the witness stand at the end of the trial and protested that he had "no idea what they [Mr. Laughlin and his mother] were going to do in court or anything else," 1962 Trial Tr. 20, his own counsel treated Appellant like a hostile witness:

"Mr. Defendant, do you feel the situation would have been different here had you talked with me, sir? Would it have changed anything here had you talked with me?" Ibid.

With surprising composure Appellant explained in some detail how consultation between attorney and client would have altered the course of the defense. 1962 Trial, pp. 20-21.

The Supreme Court has recently reiterated the fact that a criminal defendant is entitled to have "counsel [who] acts in the role of an active advocate in behalf of his client, as opposed to that of amicus curiae." Anders v. California, 35 L.W. 4385, 4387 decided May 8, 1967. (Emphasis supplied.) Appellant's trial counsel may have been seeking what he considered an appropriate result; but he plainly was not acting as an advocate for Appellant. The record reflects a situation in which Appellant was not merely denied the effective assistance of counsel; in practical effect, he had no counsel at all. See also Entsminger v. Iowa, 35 L.W. 4388, decided May 8, 1967 (S.Ct.).

In other contexts this Court has zealously protected the right of an accused to have counsel who is solely dedicated to his interests. See Ford v. U.S., No. 20,299, decided May 9, 1967. The need is particularly acute where a young defendant, inexperienced with judicial proceedings, is charged with a misdemeanor and a risk of commitment to a mental hospital for an indefinite period is involved.

Under the standards established by this Court, Appellant was denied the effective assistance of counsel;

his trial was thereby rendered grossly unfair; and counsel's disregard of Appellant's interests deprived him of substantial defenses. See Mitchell v. U.S., 104 U.S. App. D.C. 57, 259 F.2d 787 (1958), cert. denied, 358 U.S. 850; Bruce v. U.S., No. 20,146, decided April 27, 1967 (D.C. Cir.), pp.

*/
5-6. It is perhaps significant that the trial judge, after hearing Appellant's counsel cross-examine his own client, waive Appellant's right to defend the case on the merits, and urge his client's commitment, asked: "this is a trial?" **/ Tr. 23.

*/ A defendant raising the insanity defense can also contest the government's case on the merits. Holmes v. U.S., 124 U.S. App. D.C. 152, 363 F.2d 281, 282 (1966). In some situations, a tactical judgment might be made, with the consent of the defendant, to pursue one course or the other. See Clark v. United States, 104 U.S. App. D.C. 27, 259 F.2d 184 (1958); Tatum v. U.S., 88 U.S. App. D.C. 386, 190 F.2d 612 (1951). In the instant case the decision to abandon the Motion to Suppress and a defense on the merits was not justified by tactical considerations. There was no possibility that Appellant could be prejudiced in any way by vigorously pressing his Motion to Suppress. This is not a situation where the Court is being asked to second-guess a lawyer's on-the-spot decision on trial strategy. Indeed, Mr. Laughlin stated that he took it upon himself to waive a hearing on the Motion to Suppress because of his belief and Appellant's mother's belief "that this man needs treatment." 1962 Trial Tr. 22.

**/ Apparently, no one advised Appellant or his mother that the treatment available at St. Elizabeths to persons found not guilty by reason of insanity is also available to patients who enter voluntarily. By using a cross-examiner's
[Footnote continued next page]

2. Appellant Did Not Knowingly Waive His
Right to Plead Not Guilty and to Have
a Hearing on His Motion to Suppress

Neither the introduction of the insanity defense, his counsel's waiver of a hearing on his Motion to Suppress, or his counsel's waiver of Appellant's right to proceed on a not guilty plea can reasonably be imputed to Appellant. The case is closely analogous to Brookhart v. Janis, 384 U.S. 1 (1966). In that case, a defendant in an Ohio court was given a "prima facie" trial, a state court procedure in which the State makes only a prima facie showing of guilt and the defense does not put on evidence or cross-examine witnesses. Defendant's counsel had in advance of trial expressly requested the prima facie procedure. The defendant, while he did not protest the court's following this procedure, stated that he did not intend to plead guilty.

**/ [Footnote continued from previous page]
techniques, Appellant's counsel elicited from Appellant an admission that he preferred to go to St. Elizabeths than to jail. 1962 Trial Tr. 21. But this substantially misstates the alternatives. On the record, it is extremely likely that Appellant would have been found not guilty if his Motion to Suppress had been vigorously pressed.

The Supreme Court held that, under these circumstances, the defendant could not be deemed to have waived his right to plead not guilty and contest the government's proof. Furthermore, the Court held that counsel could not waive the defendant's rights under such circumstances. On the facts revealed by the transcript of the 1962 Trial, as amplified by Appellant's testimony in the 1967 Hearing, H.C. No. 179-67, the conclusion necessarily follows that Appellant did not waive his rights to plead not guilty and to have a hearing on his Motion to Suppress; nor did he acquiesce in his counsel's waiver of these rights.

A defendant who is found to be competent is entitled to make his own judgments as to where his interests lie. Any waiver of fundamental rights by a defendant is effective only if there is a clear showing of "an intentional relinquishment or abandonment of a known right or privilege." Johnson v. Zerbst, 304 U.S. 458, 464. See also Fay v. Noia, 372 U.S. 391, 439 (1963); Tatum v. U.S., 88 U.S. App. D.C. 386, 391-92, 190 F.2d 612, 617-18; Holmes v. U.S., 124 U.S. App. D.C. 152, 363 F.2d 281 (1966); Ford v. U.S., No. 20,299, decided May 9, 1967, pp. 3-4. Plainly there was no such

relinquishment in the 1962 Trial of Appellant's right to plead not guilty or his right not to introduce the insanity defense or his right to press a meritorious defense. */

Appellant's right to a fair trial was denied by the court's acceptance of his counsel's waiver of these rights on his behalf, despite his clearly stated objection in open court.

*/ Appellant had an extremely substantial argument for the suppression of evidence. See Gatlin v. U.S., supra; Kelley v. U.S., supra. The failure of Appellant's counsel to press the Motion to Suppress at the trial dramatically establishes the extent to which Appellant's counsel disregarded Appellant's interests and highlights the unfairness of the proceeding.

C. Even If the Record Were Construed As Showing That Appellant Relied on the Insanity Defense and That He Was Effectively Represented, Commitment Under Section 24-301(d) Deprived Appellant of His Constitutional Rights

1. Commitment of Appellant Without the Procedural Safeguards Available in a Civil Commitment Proceeding Denied Him the Equal Protection of the Laws

If the record were read as establishing that Appellant relied on the insanity defense himself -- an interpretation of the record which Appellant vigorously opposes -- Appellant contends that the mandatory commitment provision of Section 24-301(d) violates the equal protection concept as embodied in the Fifth Amendment. See Bolling v. Sharpe, 347 F.2d 497 (1954). Recent decisions in the Supreme Court and in this Court clearly point to this conclusion.

In Baxstrom v. Herold, 383 U.S. 107 (1966), the Supreme Court struck down a New York statute which provided for the commitment of mentally ill prisoners to a state hospital without the procedures available to a person involved in a civil commitment proceeding. Specifically, the prisoner patient could be committed without a de novo jury trial on his mental condition, to which all other civil committees were entitled.

The State urged that this represented a rational distinction -- between the "civilly insane" and the "criminally insane" . . . those with dangerous or criminal propensities."

383 U.S. at 111. The Court squarely rejected this classification for purposes of the equal protection clause, holding that "it has no relevance whatever in the context of the opportunity to show whether a person is mentally ill at all." Ibid. (Emphasis in the original.) The holding that past criminal conduct cannot justify a disparity in the procedures used to determine sanity has substantial repercussions for procedures in the District of Columbia.

The impact of Baxstrom on District procedures was forcibly demonstrated in Cameron v. Mullen, ____ U.S. App. D.C. ____, ____ F.2d ____, No. 20,308, decided March 2, 1967. In that decision the Court held that the procedure under Section 24-301(a) was not available for the commitment of a person who had not relied on an insanity defense but was found not guilty by reason of insanity. Civil commitment was held to be the exclusive route. The constitutional approach of Baxstrom lay behind the decision. The Court stated

"In the District of Columbia, the differences between commitment under Subsection (a) and civil commitment under the 1964 Hospitalization of the Mentally Ill Act [the civil commitment procedure] . . . are more pronounced than the differences struck down by the Supreme Court in Baxstrom." Slip Opin., pp. 10-11.

Among the procedures available in a civil commitment proceeding, noted by the Court, were a hearing before the Mental Health Commission and a de novo judicial hearing, with a jury if desired, on the question of sanity. Such procedures are not available for the determination of sanity in a 301(a) proceeding.

The differences between the civil commitment proceeding and the 301(d) commitment are even more dramatic. In a 301(d) proceeding, there is no hearing whatsoever on the question of present sanity. The commitment rests on the finding of the jury that the government had failed to prove beyond a reasonable doubt that the defendant was sane at a particular time in the past. Since Baxstrom holds that involvement in criminal activity does not justify the disparate New York practices for determining whether a person is presently sane or not, it is a fortiori true that dangerousness or criminal disposition will not justify the radically different treatment afforded in the District to persons found not guilty by reason of insanity. ^{*/}

^{*/} It is important to note that the Supreme Court in Lynch v. Overholser, 369 U.S. 705 (1962), did not deal with the constitutionality of 301(d). It carefully avoided having to decide the substantial constitutional issues. 369 U.S. at 709-710.

It is significant that the Court of Appeals relied on Baxstrom in its recent amendment to its decision in Rouse v. Cameron. Order of April 4, 1967, amending No. 19,863, October 10, 1966. In that Order the Court cited Baxstrom for the proposition that discrimination between those committed "under criminal proceedings" and those civilly committed raises a serious question of denial of equal protection. P. 2. In that Order the Court of Appeals not only applied the Baxstrom reasoning to a person committed under Section 301(d) rather than 301(a) -- it applied the Baxstrom reasoning to this very Appellant.

This Court has, in Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 281 F.2d 943 (1960), sustained the constitutionality of 301(d) against the assertion that mandatory commitment deprived the petitioner of his liberty without due process. The equal protection concept embodied in the Fifth Amendment was not explicitly considered by the Court.

Appellant contends that the Ragsdale case must be reconsidered in the light of the Supreme Court's Baxstrom decision and that this Court has taken a long step toward reconsidering that decision in its Mullen decision. In large part, the

Ragsdale decision rested on the fact that the mandatory commitment "statute applies to an exceptional class of people" 108 U.S. App. D.C. at 311, 281 F.2d at 946. But the "exceptional class" reasoning has been expressly repudiated by Baxstrom and Mullen. In Mullen this Court dealt with a person who had not raised the insanity defense but had nonetheless been found not guilty by reason of insanity. This Court held that the sanity of such a person could not be determined in a proceeding which differed substantially from the proceeding available to a civil committee. The same reasoning applies with equal force to the person who raises the insanity defense and is then found not guilty by reason of insanity. There is no justification for treating any person found not guilty by reason of insanity differently from the civil committee for purposes of deciding whether or not they are sane. Surely, reliance on the insanity defense does not in itself make a defendant a member of a special class.

Indeed, discrimination between classes of defendants found not guilty by reason of insanity on the basis of whether or not they rely on the insanity defense raises an equal protection problem of another dimension. A defendant whose

alleged criminal conduct is the product of a mental disease is not guilty of a crime. The defendant who relies on the claim of insanity cannot be presumed to be more in need of treatment or more dangerous to the community than the defendant who does not so rely. In view of this fact, there is no justification for holding one group committable only through a civil proceeding and the other group mandatorily committable upon a jury finding of a reasonable doubt as to sanity at some point in the past. Discrimination of this kind violates the equal protection concept as it is embodied in the due process clause of the Fifth Amendment. See Bolling v. Sharpe, 347 U.S. 497 (1954).

2. Appellant's Commitment Under Section
24-301(d) Deprived Him of Liberty
Without Due Process of Law

a. Commitments Under Section 24-301(d)
Violate Due Process of Law

Appellant contends that reconsideration of the Ragsdale opinion's holding that Section 24-301(d) does not violate procedural due process is required by recent decisions of the Supreme Court and this Court. To subject a person to commitment to a mental hospital for an indefinite term without a judicial finding that he is presently mentally ill and dangerous deprives him of his liberty without due process. The standard for determining whether an accused is not guilty by reason of insanity is whether the government has failed to prove his sanity at the time of the criminal offense charged beyond a reasonable doubt. Under Section 24-301(d) this determination is the sole ground for indefinitely committing the accused to a mental institution.^{*/} This determination has no rational

^{*/} Lynch v. Overholser, 369 U.S. 705, 706 n.5 (1962).

relation to whether the accused is suffering from a dangerous mental illness at the time of his commitment.^{*/}

The purpose of Section 24-301(d) is not to punish one who has committed a criminal act. Rather, it is to protect society and an individual suffering from mental illness from his dangerous behavior in the future and to afford treatment to the individual.^{**/} But the findings on which the Section 24-301(d) commitment is based bear no rational relationship to those purposes; they do not relate to the individual's present dangerousness or his present need for treatment of his mental condition.

The jump from a finding of a reasonable doubt as to sanity in the past to a finding of present dangerousness and

^{*/} Judge Halleck of the District of Columbia Court of General Sessions has held that mandatory commitment under Section 24-301(d) violates due process. United States v. Arduini, Crim. Nos. 10748-66, 10749-66 (D.C. Ct. Gen'l Sess. March 10, 1967). His decision is now being reviewed by the District of Columbia Court of Appeals on the government's Petition for a Writ of Mandamus. No. 3480 (original). Appellant urges the Court to consider the forceful and persuasive reasoning of Judge Halleck's opinion.

^{**/} Cameron v. Mullen, No. 20308, decided March 2, 1967 (D.C. Cir.); Ragsdale v. Overholser, 108 U.S. App. D.C. 308, 312, 281 F.2d 943, 947 (1960); see Lynch v. Overholser, 369 U.S. 705, 714 (1962).

insanity may not be made by the invocation of an artificial presumption. The Supreme Court has stated that there must be a

"rational connection between the fact proved and the fact presumed [W]here the inference is so strained as not to have a reasonable relation to the circumstances of life, as we know them, it is not competent for the legislature to create it as a rule governing the procedure of courts." Tot v. United States, 319 U.S. 463, 467-68 (1943); see United States v. Romano, 382 U.S. 136 (1965).

Plainly no such connection exists here, particularly since the not guilty by reason of insanity verdict rests on a mere reasonable doubt as to sanity at the time of the offense charged. See Lynch v. Overholser, 369 U.S. 705, 714-15.

In the Ragsdale opinion, it was suggested that Section 24-301(d) is saved from unconstitutionality by the availability of habeas corpus proceedings to the committed person; however, in such a proceeding, the burden is on the committee to prove his right to release beyond a reasonable doubt. Ragsdale v. Overholser, 108 U.S. App. D.C. at 312-13; Mullen v. Cameron, No. 20,308, at 13 n.28 (D.C. Cir. March 2, 1967). In the Ragsdale case, the Court stated,

"In a 'close' case even where the preponderance of the evidence favors the petitioner, the doubt, if reasonable doubt exists about danger to the public or the patient, cannot be resolved so as to risk danger to the public or the individual. A patient may have improved materially and appear to be a good prospect for restoration as a useful member of society; but if an 'abnormal mental condition' renders him potentially dangerous, reasonable medical doubts or reasonable judicial doubts are to be resolved in favor of the public and in favor of the subject's safety." 108 U.S. App. D.C. at 312.

This extraordinarily heavy burden of proof placed on the patient renders habeas corpus relief a wholly inadequate substitute for the required affirmative judicial finding of present, dangerous mental illness on the basis of a preponderance of the evidence in a proceeding in which the government has the burden of proof. ^{*/}

The Supreme Court's Baxstrom decision, as interpreted by this Court in Mullen, undercuts this aspect of the court's reasoning in Ragsdale. In Baxstrom, the Court held

*/ As Judge Halleck stated in United States v. Arduini, supra, at 7:

"[U]ntil [the committed person] . . . is affirmatively found to be insane, he cannot be confined indefinitely, and the burden placed upon him, as the price of release, to prove beyond a reasonable doubt that he has 'recovered' from a mental disorder that he has never been affirmatively judicially determined to be suffering from in the first instance."

that it was a denial of equal protection to deny a full hearing before a jury on the issue of sanity to one group of persons while allowing such a hearing prior to commitment to all others. The respondent in that case argued that the availability of habeas corpus was an adequate substitute for a jury trial and that therefore the petitioner was not denied equal protection of the laws. The Supreme Court ignored this argument.

As this Court held, in discussing the Baxstrom opinion,

"[T]he [Supreme] Court must have concluded that habeas corpus was no substitute for a full hearing, for the Court did not mention that remedy, although New York had urged it as an adequate safeguard. 1/

1/ "This raises the question whether habeas corpus is an adequate remedy in the District of Columbia, where the burden is on the petitioner to establish his right to release beyond a reasonable doubt." Cameron v. Mullen, No. 20,308, at 13 and n.28 (D.C. Cir. March 2, 1967). (Emphasis added.)

The Baxstrom case thus establishes that the failure to provide an adequate hearing prior to commitment is not cured by the availability of review by habeas corpus.

This Court in the Ragsdale opinion stated that the summary proceedings afforded an individual committed under Section 24-301(d) were justified by the need for speedy and

efficient procedures to protect society from him. However, the need to protect society against those who have been found not guilty by reason of insanity does not justify restricting constitutionally required procedural rights. The 1964 Hospitalization of the Mentally Ill Act, D. C. Code §§ 21-521 to 21-528, would provide immediate confinement of such persons, pending proper medical and judicial determinations of insanity.

b. Section 24-301(d) as Applied in
This Case Has Deprived Appellant of
His Rights to Procedural Due Process

Even if this Court rejects Appellant's arguments that Section 24-301(d) is unconstitutional on its face, the statute as applied in this case has deprived Appellant of his rights to due process. Appellant has been in St. Elizabeths Hospital for four and one-half years. He was found not guilty by reason of insanity of a non-violent misdemeanor carrying a maximum penalty of one year imprisonment. He has never been accorded a hearing on his present mental condition or his dangerousness in which the government has had the burden of proof.

Judge Fahy, in a concurring opinion in Ragsdale, said that Section 24-301(d) must be construed to be consistent with due process requirements.

"To do this the continued danger to society which warrants continued deprivation of liberty under section 24-301 alone must be, at least, a danger comparable to the seriousness of the offense of which the committed person was acquitted. And if that offense is of a non-violent character a more lenient approach to the question of danger is in order, particularly in connection with conditional release Moreover, if improvement by treatment does not forecast ability to adjust reasonably well to life in the community, due process may well require . . . that within a reasonable time, which will vary from case to case, continued confinement be made dependent upon civil commitment proceedings, with their greater procedural safeguards and not left indefinitely to rest alone upon commitment under section 24-301, which is more summary in nature and therefore does not afford those safeguards." 108 U.S. App. D.C. at 315-16.

Under these criteria, release or the institution of civil commitment proceedings is long overdue in this case, and Appellant's continued confinement deprives Appellant of liberty without due process.

3. Section 24-301(d) Unconstitutionally Burdens
Constitutionally Protected Rights

In the District of Columbia, the government in a criminal case must prove that the defendant had the mental capacity to commit the crime charged beyond a reasonable doubt. The sanity of the defendant is a significant facet of the government's prima facie case.^{*/} The defendant cannot waive the issue of his mental capacity; the government or the trial court, sua sponte, must inject it into the criminal proceeding in appropriate cases if the defendant does not.^{**/} These rules have stemmed from the high importance attached by the courts to the concept of moral responsibility for a criminal act:

"One of the major foundations for the structure of the criminal law is the concept of responsibility, and the law is clear that one whose acts would otherwise be criminal has committed no crime at all if because of incapacity due to age or mental condition he is not responsible for those acts. If he does not know what he is doing or cannot control his conduct or his acts are the product of a mental disease or defect,

^{*/} Lynch v. Overholser, 369 U.S. 705 (1962); Davis v. United States, 160 U.S. 469 (1895); Tatum v. United States, 88 U.S. App. D.C. 386, 190 F.2d 612 (D.C. Cir. 1951).

^{**/} Whalem v. United States, 120 U.S. App. D.C. 331, 337, 346 F.2d 812, 818 (D.C. Cir. 1965).

he is morally blameless and not criminally responsible. The judgment of society and the law in this respect is tested in any given case by an inquiry into the sanity of the accused. In other words, the legal definition of insanity in a criminal case is a codification of the moral judgment of society as respects a man's criminal responsibility; and if a man is insane in the eyes of the law, he is blameless in the eyes of society and is not subject to punishment in the criminal courts.

"In the courtroom confrontations between the individual and society the trial judge must uphold this structural foundation by refusing to allow the conviction of an obviously mentally irresponsible defendant, and when there is sufficient question as to a defendant's mental responsibility at the time of the crime, that issue must become part of the case. Just as the judge must insist that the corpus delicti be proved before a defendant who has confessed may be convicted, so too must the judge forestall the conviction of one who in the eyes of the law is not mentally responsible for his otherwise criminal acts."*/

*/ Id. at 337.

"The legal and moral traditions of the western world require that those who, of their own free will and with evil intent (sometimes called mens rea), commit acts which violate the law, shall be criminally responsible for these acts. Our traditions also require that where such acts stem from and are the product of a mental disease or defect . . . , moral blame shall not attach, and hence there will not be criminal responsibility." Durham v. United States, 94 U.S. App. D.C. 228, 242, 214 F.2d 862, 876 (D.C. Cir. 1954).

This concept of criminal responsibility and its corollary, the concept of insanity, or non-responsibility, have existed in Anglo-American jurisprudence for centuries. All states in the United States and England recognize this concept.

It is so fundamental to concepts of fairness that it is required by the due process clause of the Fifth Amendment.^{*/} Punishment for an act which was the product of a mental illness would violate the Eighth Amendment's prohibition of cruel and unusual punishment.^{**/} Moreover, the accused's right to assert a lack of mental responsibility as an absolute defense to a criminal action is guaranteed by the Fifth Amendment privilege against self-incrimination.

Any significant burden placed on an accused's right to assert the insanity defense constitutes an unconstitutional deprivation of that right. Section 24-301(d) places an unconstitutional burden on that right. It requires an accused

^{*/} See Sinclair v. State, 161 Miss. 142, 132 So. 581 (1931); State v. Strasburg, 60 Wash. 106, 110 Pac. 1020 (1910).

^{**/} Cf. Pate v. Robinson, 383 U.S. 375 (1966); Robinson v. California, 370 U.S. 660 (1962).

This is not to say, of course, that any particular formulation of the insanity standard is required. But some recognition of non-responsibility is constitutionally required.

to run the risk of a loss of liberty for an indefinite period as a condition to asserting the defense. That this burden is placed directly upon assertion of the defense alone has been made clear by Lynch v. Overholser, 369 U.S. 705 (1962), and Cameron v. Mullen, No. 20,308 (D.C. Cir. March 2, 1967).

It is obvious that loss of liberty for an indefinite period is a severe penalty. The practical effect of this burden is seen in the many cases in this jurisdiction in which criminal defendants, to whom the defense might be available, assiduously avoid asserting it in order to escape the certainty of indefinite confinement.^{*/} An accused's attorney must, in order to protect his client's liberty, in many cases advise his client to suppress an insanity defense. See U.S. v. Arduini, supra.

Such a burden on an accused's right to assert an absolute defense of insanity is clearly unconstitutional. This

^{*/} Lynch v. Overholser, 369 U.S. 705 (1962); Cameron v. Mullen, No. 20,308 (D.C. Cir. March 2, 1967); Cross v. United States, 122 U.S. App. D.C. 380, 354 F.2d 512 (D.C. Cir. 1965); Trest v. United States, 122 U.S. App. D.C. 11, 350 F.2d 794 (D.C. Cir. 1965); Whalem v. United States, 120 U.S. App. D.C. 331, 346 F.2d 812 (D.C. Cir.), cert. denied, 382 U.S. 862 (1965); United States v. Arduini, Crim. Nos. 10748-66, 10749-66 (D.C. Ct. Gen'l Sess. March 10, 1967).

burden is analogous to, and in fact heavier than, the unconstitutional burden placed on the privilege against self-incrimination by prosecutorial comment on failure to take the stand in one's own defense.^{*/} It is also similar to unconstitutional burdens placed upon an accused's procedural right to a jury trial, to appeal, or to request a new trial trial.^{**/} Section 24-301(d) must be held to be an unconstitutional burden on constitutionally protected rights.

^{*/} Griffin v. California, 380 U.S. 609 (1965); cf. Spevack v. Klein, 385 U.S. 511 (1967).

^{**/} See Marano v. United States, No. 6843 (1st Cir. March 23, 1967); United States v. Jackson, 35 U.S.L.Wk. 2411 (D. Conn. January 9, 1967); Patton v. North Carolina, 256 F. Supp. 225 (W.D.N.C. 1966).

One could persuasively argue that Section 24-301(d) also places an unconstitutional burden on an accused's right to a full hearing before a jury on the question of present, dangerous mental illness, by conditioning that Fifth Amendment right on foregoing the absolute defense of insanity in a criminal trial. See United States v. Arduini, supra at 10.

4. The Burden of Proving Present Sanity Was
Improperly Imposed on Appellant in the
District Court in H.C. 287-65

If the Court rejects all of Appellant's preceding arguments, Appellant contends that it is improper for the burden of proving present sanity to be placed on petitioner in a habeas corpus proceeding seeking release from St. Elizabeths Hospital after a finding of not guilty by reason of insanity. Even if Baxstrom and Mullen are not held to require a holding that Section 24-301(d) is unconstitutional, the reasoning of these two cases, at the least, compels the conclusion that in a habeas corpus proceeding the burden of proving present mental illness and dangerousness should be on the government. A hearing in which the burden is on the petitioner to establish beyond a reasonable doubt that he is sane and no longer dangerous plainly is no equivalent for the hearing provided in a civil commitment proceeding. The further requirement that he prove that the Superintendent acted arbitrarily and capriciously in denying his release, see 1967 Hearing Tr. 407-08, is a further inappropriate discrimination.

Appellant submits that the government did not, in the hearing below, H.C. 287-65, bear the burden of establishing that Appellant would be dangerous to himself or others by reason of mental illness in the foreseeable future. The government relied on the testimony of Dr. Economon that he considered Appellant dangerous, although the doctor did not elaborate on this opinion or state whether the danger would be due to mental illness. 1967 Hearing Tr. 114 Dr. Israel Zwerling also testified that there might be some risk if Appellant were released. Zwerling Dep. 74-75. On the other side, Appellant adduced full testimony from Dr. Clarence Bunge, a member of the Mental Health Commission, that continued hospitalization was no longer justified. 1967 Hearing Tr. 288, and, generally 283-90.

On this record, it is clear that there is insufficient evidence to justify Appellant's further confinement. ^{*/}

*/ There was also contradictory evidence adduced on this question in the 1965 hearing. But this evidence, now 1-1/2 years old, is insufficient to make the government's case on present mental condition.

II. THE EVIDENCE INTRODUCED AT THE REMAND HEARING ESTABLISHED THAT APPELLANT HAS NOT RECEIVED ADEQUATE TREATMENT AND IS ENTITLED TO A CONDITIONAL RELEASE UNDER THE CRITERIA ESTABLISHED BY THIS COURT

On remand from this Court's decision of October 10, 1966, a hearing was held before Judge Holtzoff beginning on January 9, 1967. In its decision this Court directed the district court to inquire generally into the standards of adequate treatment with specific reference to the appropriateness and adequacy of the treatment afforded to Appellant. Slip opin., pp. 8-12. It further stated that the district court could give the Hospital a reasonable opportunity to begin giving Appellant adequate treatment or, under the appropriate circumstances, the Court could order Appellant's release. Slip opin., p. 13.

Despite the fact that the judge arbitrarily limited the number of expert witnesses which Appellant could call, erroneously denied Appellant's request for depositions, unreasonably limited Appellant's counsel's examination of witnesses, constantly interrupted Appellant's counsel and made it impossible for him to fully develop his case, the record before this Court establishes that Appellant has not received adequate treatment and that he is entitled to, at the least, a conditional release.

A. The Burden of Proof Should Have Been on the Government To Establish the Adequacy of the Treatment Afforded Appellant

The judge improperly ruled that the burden of proof was on Appellant to establish the inadequacy of the treatment afforded by the Hospital. 1967 Hearing Tr. 346. This ruling was plainly at variance with this Court's Rouse decision. The Court there stated:

"This requires the hospital to show that initial and periodic inquiries are made into the needs and conditions of the patient with a view to providing suitable treatment for him, and that the program provided is suited to his particular needs." Slip opin., pp. 8-9.

The situation is analogous to Lake v. Cameron, ____ U.S. App. D.C. ____, 364 F.2d 905 (1966), cert. denied, 382 U.S. 863. Holding that alternative modes of treatment for an aged petitioner must be explored, this Court stated that the burden of exploring such alternatives was on the government. 364 F.2d at 660-61. The facts relevant to the determination were within the government's knowledge, and the indigent petitioner lacked the resources to establish the facts necessary to obtain her release from the Hospital.

Ibid. ^{*/} The same circumstances militate for placing the burden on the government in this case. ^{**/} The burden of proving the adequacy of treatment must be on the government if the congressionally declared right to adequate treatment is not to become meaningless.

B. The Standard Which the Court Should Have Applied Is Whether the Treatment Afforded Is "Adequate in Light of Present Knowledge"

The formulation of the standards for adequate treatment is extremely difficult. In its Rouse decision this

*/ It is probably true that the petitioner must make a prima facie showing as to the inadequacy of treatment before the burden shifts to the government. Cf. Tatum v. U.S., 88 U.S. App. D.C. 386, 389, 190 F.2d 612, 615 (1951). In this case, there can be no doubt that Appellant has made a sufficient showing to shift the burden to the government. In the analogous context of proceedings involving juveniles, it would be wholly untenable to impose the burden of proof on the juvenile claiming inadequate treatment. See Creek v. Stone, No. 20,563, opin. filed May 1, 1967 (D.C. Cir.); In re Gault, S.Ct., No. 116, May 15, 1967, p. 20 n. 30.

**/ Appellant had in the District Court a foundation grant, which permitted him to obtain expert witnesses on the treatment question. However, in other cases, petitioners will not be so fortunate. This Court has suggested that courts appoint independent experts to assist in the determination. Rouse v. Cameron, Slip opin., p. 10. While this procedure would help the court in reaching an informed judgment, it would not help a petitioner to bear the burden of proving inadequacy of treatment.

Court directed an inquiry into whether the treatment of a particular patient was "too insubstantial in comparison with what is available" and stated that the Hospital should "provide treatment which is adequate in light of present knowledge." Slip opin., p. 9. Appellant maintains that the adequacy of treatment must be measured against the principles of treatment prescribed by the psychiatric school to which the treating doctors subscribe, so long as the school is a recognized one. See Pross, Torts § 31 (2d ed., 1955). If treatment practices as to a particular patient fall below the level of accepted principles or diverge dramatically from them, the treatment must be regarded as inadequate.

Appellant contends that the judge below applied an erroneous standard of adequacy. The judge indicated that the proper standard was the level of treatment which was afforded in other public mental hospitals. 1967 Hearing Tr. 342, 344. Hence he attached great weight to the fact that St. Elizabeths was accredited by the Joint Committee on Hospitals while many other public mental hospitals are not. Id. at 342.

This standard is at odds with the decision of this Court. The Rouse decision stated:

"In the opinion of the American Psychiatric Association no tax-supported hospital in the United States can be considered adequately staffed." Slip opin., p. 12.

The connection between inadequate staff and inadequate treatment has been recognized by Dr. Cameron himself. He has stated that "if . . . the hospital [has] inadequate staff, I suspect that the right to treatment would be rather illusory" Hearings on S. 935, 88th Cong., 1st Sess. (1963), p. 142. The fact that other public hospitals are inadequately staffed or provide inadequate treatment, for whatever reason, does not mean that St. Elizabeths is justified in providing treatment to Appellant at that inadequate level.^{*/}

The judge below referred to the inadequacy of resources at St. Elizabeths and suggested that the expectations of treatment must be tempered in the context of the inadequate resources allocated to the Hospital. See 1967 Hearing Tr. 409, 414. But this Court's decision expressly repudiated this view. The opinion states: "Continued failure to provide suitable and adequate treatment

^{*/} The judge below suggested that the Rouse decision of this Court was directed against the situation where a patient was receiving no treatment at all. 1967 Hearing Tr. 348, 409. The decision is absolutely clear, however, that a patient is entitled to receive adequate treatment. Slip opin., pp. 8-14.

cannot be justified by lack of staff or facilities."

Slip opin., p. 11. The Court noted that proposed language that would have conditioned the right to treatment on the availability of resources was rejected by Congress.

Ibid. The rejection of this approach is necessary in view of the therapeutic justification for involuntary commitment and the substantial constitutional issues raised by the failure to provide adequate treatment.

C. On the Evidence Adduced Below, the Government
Did Not Show That Appellant Was Receiving
Adequate Treatment

Despite the fact that the judge gave the government wide leeway to prove the adequacy of the treatment afforded Appellant while severely hampering Appellant's efforts to present his position, the record shows that the government failed to bear its burden. Rather, it establishes that Appellant has not received adequate treatment.

1. The Basic Treatment Which the Hospital
Claimed Was Afforded to Appellant Was
Milieu Therapy

Both Dr. Economon and Dr. Cameron testified that the basic therapy available to Appellant was milieu therapy. 1967 Hearing Tr. 42, 57, 115, 155. They used this term in the sense generally accepted within the profession. Id. at 73. They both recognized that an appraisal of the adequacy of such therapy for this Appellant requires a detailed review of the transactions on the ward and the day-to-day activity of Appellant. 1967 Hearing Tr. 155-63. The Court's remand order, noting the Hospital's past reliance on the efficacy of milieu therapy, specifically directed an inquiry into "the

suitability and adequacy of the 'milieu' as therapy for this petitioner" Slip opin, p. 14.

The record states that Appellant received no psychotherapy, group or individual, since February, 1965. Psychiatric Notes, March 2, 1965. Both doctors stated that individual psychotherapy would be useful for Appellant, but stated that the Hospital had been unable to provide it for him. 1967 Hearing Tr. 37, 39, 175-77.*/

2. The Testimony of Dr. Cameron -- The Inadequacy of Staff

The government's first witness was Appellee, Dr. Cameron, who testified that the Hospital was inadequately staffed when judged by its own standards. He testified that the Hospital had, in 1962, reviewed its treatment facilities and staffing and set "a very, very conservative estimate of what we would need in John Howard as far as physicians were concerned." 1967 Hearing Tr. 14. In that conservative study, made five years ago,

*/ Appellant's former ward administrator, Dr. Agler, had apparently recommended individual psychotherapy for Appellant as long ago as June 22, 1964, but it was never provided. See Psychiatric Notes June 22, 1964, August 12, 1964.

the Hospital concluded on "an intermediate goal of at least three-quarters of an hour of physician's time per week for each patient." Ibid. Dr. Cameron testified that he thought that this figure was far too little, even as an intermediate goal. Id. at 14-15. This intermediate goal has not been reached in John Howard Pavilion.

Dr. Cameron testified that the "intermediate goal" of three-quarters of an hour per patient had almost been reached at the present time. On cross-examination, however, he conceded that his calculation of the present staffing did not take into account the fact that psychiatrists in John Howard Pavilion spend roughly one-third of their time in court or preparing to testify in court. 1967 Hearing Tr. 53. This factor alone drops the available time for treatment of patients to roughly two-thirds of the conservative staffing goal adopted by the Hospital five years ago. Dr. Cameron also testified that the amount of time spent by doctors in John Howard in pretrial evaluation of patients referred to the Hospital for examination was very substantial, and was not considered in his estimate of the psychiatrists' time available for treatment in John Howard. 1967 Hearing

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Tr. 56. Hence, the psychiatric personnel are well below the conservative interim standard adopted in 1965.

According to Dr. Cameron's testimony, John Howard was severely understaffed in the categories of other therapeutic personnel. The conservative, interim goals adopted in 1962 indicated a need for 15 occupational therapists; there are now about three or four. The study called for nine or ten recreational therapists; there are now two or three. The study called for six or seven psychologists; there are now three. 1967 Hearing Tr. 17. The study called for six social workers; there are now three. Id. at 18.

The government also introduced through Dr. Cameron the Standards for Hospitals and Clinics published by the American Psychiatric Association. Respondent's Exhibit 2. The pamphlet contains, on page 61, a chart setting forth minimum staff-patient

*/ On cross-examination Dr. Cameron stated that his estimate of present staff treatment time was based on the figure of 8.7 physicians in John Howard. It is worth noting that this number includes residents, still in training, and a medical officer who does not have any psychiatric responsibilities. There are, in fact, seven fully trained psychiatrists for the 350 patients in John Howard. 1967 Hearing Tr. 49.

ratios. Dr. Cameron stated that many experts considered these standards, which were published in 1956 and republished in 1958, very badly out of date. 1967 Hearing Tr. 12. And he further stated that he disliked the use of these standards. Id. at 57. Indeed, he testified that it was the inadequacy of the standards which motivated the 1962 reappraisal of the staffing needs of St. Elizabeths Hospital.

The APA standards presuppose two categories of patients: those receiving "intensive treatment" and those receiving "continued treatment." On the basis of these categories, the APA prescribes minimum staff to patient ratios. ^{*/} The prescribed

^{*/} Appellant submits that the "continued treatment" category is a polite euphemism for the back-ward custodial care which, regrettably, exists in many mental hospitals. This is reflected by the fact that one doctor is considered sufficient to care for 150 patients. Appellant submits that this figure has no relevance for John Howard, virtually none of whose patients are chronic cases requiring only custodial attention. The suggestion, incorporated in Respondent's Exhibit 3, that any patient resident in the Hospital for more than a year can be grouped as a "continued treatment" case is wholly unacceptable. Indeed, Dr. Cameron repudiated the suggestion that such patients need not be given active treatment. 1967 Hearing Tr. 48.

minimum doctor-patient ratio for intensive treatment is one doctor for 30 patients. In John Howard, by the Hospital's calculation, the ratio is one doctor for 41 patients. The Hospital's calculation is based on 8.7 psychiatrists in John Howard. However, as noted above, there are, in fact, only seven fully-trained psychiatrists in that service. Moreover, they have, because of the peculiar population of the service, unusually heavy obligations to appear in court. Correcting the calculations to take into account these two factors, the psychiatrist to patient ratio, in terms of available time in the Hospital, is one doctor for every seventy-five patients.^{*/} Thus, by any calculation, the staffing of John Howard is considerably below the APA standard, a standard which Dr. Cameron stressed was adopted as a minimum standard 13 years ago. 1967 Hearing Tr. 51-52.

In explaining the significance of these standards, Dr. Cameron stated that "it was assumed by the publishers of the

^{*/} This ratio does not take into account the "substantial" amount of time that the doctors spend in pretrial evaluation, another unusual responsibility of the John Howard staff.

standards that if you had less employees than in the various categories listed here, you did not have the minimal number required, and you could not be providing really adequate treatment." 1967 Hearing Tr. 52.

The net of Dr. Cameron's testimony, then, was that the present staffing of John Howard Pavilion was very considerably below the conservative standards which the Hospital had set for itself five years ago, and below the APA standards. He plainly indicated that he thought John Howard was inadequately staffed. 1967 Hearing Tr. 15, 16. Nonetheless, Dr. Cameron concluded that he thought Appellant was receiving treatment which "was adequate, even though not ideal." 1967 Hearing Tr. 43. The weight to be attached to this latter opinion is open to question, however, since he testified on cross-examination that he was not sufficiently familiar with plans for Appellant's treatment to express an opinion on their adequacy. 1967 Hearing Tr. 69.^{*/}

^{*/} Indeed, the judge objected to Appellant's counsel even cross-examining Dr. Cameron on the adequacy of Appellant's treatment, on the ground that it was beyond the scope of the doctor's information. 1967 Hearing Tr. 68. He had not objected to Dr. Cameron's giving his opinion on the adequacy of Appellant's treatment on direct. 1967 Hearing Tr. 43.

3. Appellant's Expert Witnesses -- The
Inadequacy of the Milieu Therapy Program

Appellant introduced the depositions of two experts who testified on the adequacy of the treatment afforded Appellant. ^{*/} Both experts had carefully reviewed all hospital records on Appellant; they had read the transcript on the 1965 Hearing before Judge Holtzoff; they had had an hour and a half interview with Appellant; and they heard all the testimony of Dr. Cameron, Dr. Economon, and a nursing assistant from Appellant's ward. Zwerling Dep. 7-8; 1967 Hearing Tr. 201-02. Dr. Zwerling testified that he had, as a consultant for the National Institute of Mental Health, frequently passed on the adequacy of treatment programs in mental hospitals on the basis of hospital records alone. Zwerling Dep. 6.

Dr. Zwerling, the Director of Bronx State Hospital, Professor of Psychiatry at Albert Einstein College of Medicine and the author of about 30 articles on the care of mental

*/ Appellant's expert witnesses' testimony was taken on deposition by consent of both parties. One of the witnesses appeared briefly in court, but his substantive testimony was presented on deposition.

patients, testified that the treatment afforded to Appellant deviated substantially from the standards of milieu therapy accepted by the profession. Zwerling Dep. 13. He stated several times that he had seen no indications that a program of milieu therapy was in progress at all. Id. at 53, 65, 80. Not only were the hospital records devoid of any reference to a program of milieu therapy, but there were numerous indications that there was no such program. Id. at 13-14, 65. He summarized his testimony by stating that he found "no indication of a rational program of treatment afforded to Mr. Rouse." Id. at 80.

Dr. Alan Kraft, the Director of the Fort Logan Mental Health Center, Denver, Colorado, and the author of the chapter on "The Therapeutic Community" in the American Handbook of Psychiatry, testified that the treatment afforded to Appellant only "minimally comports" with the standards of milieu therapy. Kraft Dep. 19. He further stated that the Hospital staff's theoretical allegiance to the principles of milieu therapy had "not been adequately translated into action." Kraft Dep. 36.

As important as their ultimate opinions as to adequacy of treatment were, the specific observations Drs. Kraft and

Zwerling made about the disparities between milieu therapy, as the technique is understood in the profession, and the treatment afforded to Appellant were highly significant and relevant to the issue of adequacy. Both expert witnesses agreed on a number of generally accepted characteristics of a milieu thereapy program:

1. Of primary importance is the adoption of a treatment plan tailored to the needs of the particular patient. Kraft Dep. 11; Zwerling Dep. 19. Both doctors emphasized that the accepted practice in the profession is to review the treatment plan periodically to assure that it is effectively dealing with the patient's illness. Kraft Dep. 13; Zwerling Dep. 20-21.

The undisputed evidence is that no such specific plan for the treatment of Appellant was ever adopted. Dr. Economon testified that he merely continued "a program of treatment [which] has been extant in John Howard Pavilion long before I entered the building." 1967 Hearing Tr. 115. He "modulated" it in unspecified ways for Appellant's needs. The only suggestion of a plan for Appellant was hardly specific. Dr. Economon stated that after reviewing Appellant's case,

"I, therefore, came to the conclusion, having conferred with the ward staff and reading his history and based on knowledge of people with

this particular disorder, that Mr. Rouse needed the healthy forces that are generated by environmental therapy, by living within the group, controlled and monitored by the psychiatrist and the staff people. . . ."
1967 Hearing Tr. 170.

There is no suggestion that this approach to Appellant's treatment was ever reviewed.

2. Dr. Kraft and Dr. Zwerling testified that the generally accepted standard in milieu therapy is to have the chief therapist participating in ward life daily.
Kraft Dep. 5; Zwerling Dep. 19.

In contrast, Dr. Economon testified that he saw Appellant only every two or three weeks. 1967 Hearing Tr. 146.

3. Drs. Zwerling and Kraft testified that counseling with the family of the patient is generally accepted as an important element of the treatment. Zwerling Dep. 19-20; Kraft Dep. 12. This is particularly important in the present situation, in which the family and the patient are in frequent contact. Kraft Dep. 12.

The record reflects that the Hospital personnel have had virtually no contact with the family of Appellant. The

psychiatrists' notes reflect two meetings with Appellant's mother. The first meeting was with a psychiatric social worker. He stated that she was glad to talk with someone from the Hospital and that she hoped to be able to do so again in the future. He concluded "that the mother can be considered a future resource." Psychiatric Notes, Initial Social Service Interview, December 5, 1962, p. 3. The other meeting was with Dr. David Owens, "after several telephone calls more or less demanding an interview with [him]". Psychiatric Notes, October 24, 1963. She complained about the inadequacy of the treatment being afforded Appellant. Dr. Owens terminated the interview and she left angrily. Ibid. The Psychiatric Notes do not reflect any further efforts to work with the mother or utilize this treatment resource.

4. Dr. Zwerling testified that the relationship established between the doctor and patient was of great importance in a milieu therapy program, and that the relationship between Dr. Economon and Appellant was not of a kind considered appropriate within the profession. Zwerling Dep. 15-19. He noted that Dr. Economon's notes on the

Appellant reflect a tone of anger and moral censure. Ibid.

While it is true that Dr. Economon testified, "I still maintain my love for Mr. Rouse," his notes reflect a very different tone. See, e.g., Psychiatric Notes, April 15, 1966 (1 & 2); November 30, 1966. Furthermore, his gratuitous announcement in open court that he had been administering placebo medication to Appellant, a fact without evidentiary significance, further suggests his hostility to Appellant. 1967 Hearing 182-83; see Zwerling Dep. 18.

4. The Hospital Records Indicate That
Appellant Did Not Receive Adequate
Treatment

The hospital records themselves, Petitioner's Exhibits 1 and 2, most dramatically demonstrate the inadequacy of the treatment afforded to Appellant. */

The Nursing Notes are kept on a regular basis by the nursing aides on the patient's ward. While they might be considered of limited significance in other treatment programs, they are extremely important in a milieu therapy program. The basic therapy is supposed to be the interactions on the ward, and the aides are supposed to be

*/ The Hospital is under a statutory duty to keep records of all treatment administered to patients. D. C. Code § 21-562 (1961, Supp. V).

important therapeutic personnel. The nursing aides are instructed in preparing these notes by the Educational Branch of the Nursing Service and by the doctor in charge of the ward. 1967 Hearing, p. 320.^{*}

It is because of these considerations that Dr. Zwerling attached such great weight to the fact that the nursing notes contained affirmative indications that there was no milieu therapy program being offered to Appellant. Rather, they reflect a traditional custodial orientation. Zwerling Dep. 64-65; see Kraft Dep. 17.

The notes constantly reflect a concern with neatness, cooperativeness, and attention to ward detail. Appellant stands very well with regard to each of these categories, and throughout most of the period of his detention he was considered a model patient. A typical entry is the note of July 30, 1964:

"This pt. is cooperative and causes no problem on ward. Very neat in appearance. Speaks

^{*}/ The Nursing Notes available to Appellant begin with June 28, 1963. Appellant's counsel was informed by the Librarian at St. Elizabeths Hospital that the prior Nursing Notes had been lost. For the convenience of the Court, Appellant will have the Nursing Notes, which are written by hand, typed; a typed copy will be lodged with the Clerk.

well & enjoys discussing most any subject. Pt. eats & sleeps well. Spends most of his time watching TV in his room."

Another is the entry of January 29, 1966:

"This patient's behavior is the same as stated in previous notes. Patient is cooperative with ward routine. He seems to get along well with other patients on this shift. He spends his time playing cards, watching TV and reading. Patient has a good appetite, is fairly neat in appearance, clean in habits."

What the Nursing Notes conspicuously lack are references to therapeutic interventions by ward personnel in Appellant's activities. Dr. Economon testified that ward personnel attempt on the ward "to create meaningful experiences, learning experiences, be they profound or mundane." 1967 Hearing Tr. 157-58. See Kraft Dep. 3-4. But the significant fact is that the Nursing Notes contain virtually no instances of such efforts by the personnel to develop such experiences. While Dr. Economon was at pains to stress the inadequacy of the notes maintained on treatment, see, e.g., 1967 Hearing Tr. 147, 149, the fact remains that copious notes were kept by the ward staff. And it defies belief to think that they took full notes on matters of little interest to them -- i.e., cooperation and neatness -- while failing

to record the events which they considered central to the treatment program. See Zwerling Dep. 65.

It is also significant that in his 4-1/2 years in John Howard, Appellant never once engaged in any violent altercation. ^{*/}

Furthermore, there is a considerable disparity between the image of the cooperative, responsible patient which emerges from the Nursing Notes and the "viciously sociopathic" patient occasionally described in the Psychiatric Notes. This disparity was noted by Dr. Zwerling in casting some doubt on the adequacy of communication between the doctor and the ward staff. ^{**/} Zwerling Dep. 17.

*/ This is particularly striking since John Howard is far from a peaceful place. In another case now pending before this Court, Appellant was prepared to prove that during the period from January 1, 1966, to August 24, 1966, in John Howard, there were 46 consummated assaults, 27 of which resulted in injuries. Dobson v. Cameron, No. 20,573, Brief for Appellant, p. 41.

**/ It should be noted that the tone of the Nursing Notes changed considerably after the decision of this Court in Rouse v. Cameron, No. 19,863, on October 10, 1966, as the remand hearing approached. For example, on November 29, 1966, a nurse wrote a note stating that Appellant was "most usually anti-social on the ward. He is so outspoken and aggressive in his conversation, that most people on the ward avoid him." Significantly, this was the first behavior note

(Footnote continued)

The Psychiatric Notes buttress the conclusion that Appellant was not engaged in an active treatment program. These Notes are devoid of any statements reflecting a systematic plan for the treatment of Appellant's illness. There are scattered references to the therapeutic quality of the hospital milieu, but usually in the context of Appellant's failure to respond to the milieu or his ignoring it. See, e.g., Psychiatric Notes, Aug. 12, 1964, April 30, 1965.

The Psychiatric Notes mention relatively few contacts between the psychiatrist and Appellant. The first note is an extensive admission note of November 15, 1962. This note, together with a Psychiatric Case Study, February 7, 1963, and the record of a Staff Conference, February 21, 1963, describe Appellant's background and symptoms in exhaustive detail,

**/ (Continued from previous page)
written by a nurse during Appellant's 4-1/2 years on John Howard. And the vicious qualities described had not previously been noted in the Nursing Notes. Dr. Economon's Psychiatric Note of the following day adds to this the fact that Appellant often "forgets, conveniently, to do details on his ward" Psychiatric Notes, November 30, 1966. Since all Nursing Notes state that Appellant has always performed his ward detail without problems, these notes are open to the inference that Dr. Economon and the nurses were "making a record" for the remand hearing.

It is also noteworthy that the Psychiatric Note of November 30, 1966, the most sharply critical in the file, was written only four months after Dr. Economon recommended Appellant for transfer to a less secure service.

but they do not contain a word on the appropriate treatment
of Appellant's illness. ^{*/}

Aside from his diagnostic sessions, the Psychiatric Notes do not reflect any therapeutic encounters between Appellant and a psychiatrist between his admission on November 9, 1962 and his first habeas corpus hearing on June 22, 1964 -- a period of approximately one and a half years. There is no suggestion in the Psychiatric Notes that any treatment was undertaken during this period. No treatment plan was ever adopted for him, and no psychotherapy was undertaken during this period.

*/ The Admission Note states that Appellant gave a grandiose description of his past criminal activities. This grandiosity and the unreliability of the information provided was noted at the time and has been remarked on subsequently. Psychiatric Case Study, February 7, 1963, p. 5; Testimony of Dr. Economon, 1965 Hearing, pp. 24-25, 27.

There is no substantiation for any of these past activities. 1965 Hearings, p. 27. Curiously, the offenses recounted by Appellant were accepted as established facts by the Hospital for diagnostic purposes. His stories of past activities became "a long history of anti-social behavior dating back to early childhood with a number of arrests such as robbery, housebreaking, forgery, and grand larceny." Medical Staff Conference Note, February 21, 1963. This anti-social history became the basis for the diagnosis of Anti-social Reaction with which Appellant began his Hospital career. See also Psychiatric Note, August 5, 1966.

The subsequent Psychiatric Notes -- from August, 1964 through January 9, 1967 -- do not reflect that treatment was being afforded to Appellant, with the exception of a seven month period of group psychotherapy. In Dr. Economon's first Psychiatric Note, he stated that he would attempt to find Appellant an opportunity for individual psychotherapy. Psychiatric Notes, August 12, 1964. He further stated:

"The therapeutic ward milieu is available to him [Appellant] but he generally denies its existence and tends rather to spend his time in minor forms of manipulative behavior, such as playing various individuals off in his behalf." Ibid.

This excerpt reflects a dominant theme of the subsequent Psychiatric Notes, down to January, 1967: Appellant should stop his "manipulative behavior" and stop "rejecting" the therapeutic milieu. For example, on July 1, 1965, Dr. Economon wrote that Appellant "is actively engaged in not seeking that which is available in the therapeutic milieu." Again, on April 15, 1966, after discovering that Appellant had been writing amorous letters to two pen pals, Dr. Economon wrote that Appellant "continues to be the classic sociopath." The Psychiatric Notes are totally devoid of any indication of a systematic effort to treat Appellant's diagnosed illness. The notes contain a condemnation of Appellant's behavior, but

they do not contain a systematic, affirmative program to change it.

Less than four months after Dr. Economon sharply condemned Appellant's "viciously sociopathic" behavior, Psychiatric Notes, April 15, 1966 (2), he recommended Appellant for transfer out of John Howard Pavilion. Psychiatric Notes, August 5, 1966. He stated that Appellant was "well adjusted in this building" and that he "has now reached the point of diminishing returns." Ibid. Appellant's adjustment on the most privileged ward was characterized as "excellent, save for a lack of involvement and caring for people." Ibid. His recommendation was approved by the Acting Superintendent on September 28, 1966. Despite this recommendation and approval, Appellant was not transferred for 3-1/2 months, until after the hearing in January, 1967. ^{*/}

*/ The reason for the delay given in the Psychiatric Notes, as of October, 1966, was lack of bed space. Dr. Owens testified that Appellant would not have been transferred in any event, because of the Hospital's policy of not transferring patients while a habeas corpus petition is pending. 1967 Hearing, pp. 263-64. The constitutional questions raised by this policy, to the extent that it is followed, have apparently never been explored.

5. The Testimony of Dr. Economon and the Other Hospital Personnel Does Not Rebut the Substantial Evidence That the Treatment Afforded Appellant Was Inadequate

The remand decision of this Court in the Rouse case stated that the district court should explore the suitability and sufficiency of the treatment afforded to Appellant with specific reference to his needs and his illness. Slip. Opin., pp. 13-14. In particular, the court directed inquiry toward "the suitability and adequacy of the 'milieu' as therapy for this petitioner" Slip Opin., p. 14. The government failed to establish the nexus between the milieu and the treatment of Appellant's illness, and it failed to show the suitability of the treatment afforded by the Hospital for his particular illness.

The basic description of the therapy afforded to petitioner was given by Dr. Economon. He testified in a general way as to the approach taken with all patients in John Howard, with the explanation that "it is very difficult for a person who is quote not in the business to understand really what is going on." 1967 Hearing Tr. 160.

He explained that milieu therapy presupposes that the Hospital "is an extension of society, a well extension." Id.

at 155-56. He further testified:

"In John Howard we are in a sense a large family. The hospital is a very big family. John Howard is somewhat smaller. The wards are the smallest families. There are people there who are symbolic of mother, father, uncle, cousin. There is authority there, obviously, because there is authority in the real world. There is also the notion that, You, my child or you my patient do what you can, I will be back of you assessing what you are doing, imposing external controls when you falter and lack your own internal controls. This happens in the family; this happens as well in John Howard. There is really very little difference. It's merely a continuum of the real world." Id. at 157.

However, his testimony was very thin, when the issue was the relevance of milieu therapy as practiced in John Howard to Appellant's illness.

Dr. Economon described the system in operation in two situations:

1. Appellant was found to have been drinking on the ward. Dr. Economon testified that, after consultation, he told Appellant, "You go back on the ward and let's not see this happen again." Id. at 171.

2. Appellant's father died. In addition to arranging for Appellant to attend the funeral, Dr. Economon turned the event to "therapeutic use." Id. at 174. His approach was

"a common sensical one, namely, in which your grief is shared by me you have no father and you must work through your own feelings about him." Id. at 174-75.

Aside from these incidents, Appellant's counsel's prolonged effort to obtain specific descriptions of the milieu system as it operated on Appellant were unavailing. Id. at 164-67.^{*/}

Appellant submits that these two incidents reflect a simple ad hoc reaction to Appellant's problems that cannot properly be dignified by the name "milieu therapy." They are not suggestive of a systematic approach and they seem peculiarly ill-suited to effect a fundamental amelioration in Appellant's mental condition.

The same randomness in Appellant's treatment is apparent from Dr. Economon's attitude toward occupational therapy. Dr. Economon testified:

"Attempts were made to have him involve himself in occupational therapy. There he displayed a lack of interest and a lack of

*/ Another incident, reflected in the Psychiatric Notes and described at the hearing, 1967 Hearing Tr. 108-11, involved love letters which Appellant was sending to two pen pals. Dr. Economon's therapeutic responses, described only in the Notes, were (a) to tell Appellant to write letters of apology and (b) to begin censoring Appellant's mail "in order to protect the weaker members of the community from his lying onslaughts." Psychiatric Notes, April 15, 1966 (1 & 2).

attendance which made it necessary for that staff to reject his behavior and say that he can no longer make use of something that he was not involved with or interested in." 1967 Hearing Tr. 118.

The occupational therapy for which Appellant was recommended was rudimentary woodwork. Apparently, no inquiry was made by the Hospital staff into the appropriateness of such therapy for Appellant. Of what relevance would such a skill be to a high school graduate of superior intelligence with a very considerable knowledge of electronics? Woodworking cannot be presumed to be therapeutic for everyone. Dr. Kraft introduced a refreshing note of reality on this subject: "Realistically, the activities involved in occupational therapy may not be helpful to him and he might correctly assess the situation." Kraft, Dep. 9.

Dr. Economon mentioned in almost an off-hand way the fact that Appellant had undertaken and completed with good grades several correspondence courses. Psychiatric Note, August 5, 1966. The nursing notes are replete with evidence of his dedication to the study of electronics. Yet no efforts were made to turn this interest to therapeutic ends. Such undifferentiated treatment, undertaken without reference to the petitioner's peculiar problems, interests, or goals, is precisely the practice criticized by this Court in its Rouse decision.

In terms of practices, rather than philosophy, the evidence reflects a system completely at odds with the system of milieu therapy generally accepted in the profession, as described by Dr. Zwerling and Dr. Kraft. The psychiatrist rarely appears on the ward. No treatment plan for the patient, designed specifically to cope with his needs, is ever adopted. The therapeutic activities in which Appellant is supposed to participate are not part of any general plan but are chosen at random.

The above evidence -- in particular Dr. Cameron's testimony as to inadequacy of staff; Dr. Zwerling's testimony as to the lack of any treatment program; and Dr. Economon's testimony setting forth heady principles and haphazard implementation -- adds up to a conclusive showing that Appellant did not receive adequate treatment.

D. Given the Inadequacy of the Treatment Afforded,
Appellant Is Entitled to a Conditional Release

In its decision remanding the case to the District Court for further hearings, this Court stated that "Unconditional or conditional release may be in order if it appears that the opportunity for treatment has been exhausted or treatment is otherwise inappropriate." Slip opin., p. 13. The opinion lists a number of "important considerations" to be taken into account in deciding whether the Hospital should be given a further opportunity to initiate a treatment program:

- [1] "length of time the patient has lacked adequate treatment,
- [2] the length of time he has been in custody,
- [3] the nature of the mental condition that caused his acquittal, and
- [4] the degree of danger, resulting from the condition, that the patient would present if released." Ibid.

Appellant urges that, based on each of these criteria, the Hospital has exhausted its opportunity to provide treatment and he is therefore entitled to a conditional release:

1. Appellant has lacked adequate treatment throughout the 4-1/2 years of his hospitalization. At no time was a systematic effort made to treat his mental illness. For a period of 7 months, more than two years ago, he was afforded group psychotherapy. Since that time he has not received psychotherapy of any kind or any other treatment which might have comparable therapeutic benefits. His only treatment has been exposure to the environment of the Hospital.

2. Appellant has been a patient for 4-1/2 years after being found not guilty of an offense carrying a maximum sentence of 12 months. During this entire time, the Hospital has not been able to develop an effective treatment plan. It unreasonably prejudices Appellant to permit the Hospital now, after 4-1/2 years, to begin to try to develop a meaningful program. Almost three years ago Judge Hart urged the Hospital to work out a program for Appellant's conditional release. Psychiatric Notes, June 22, 1964.

3. Appellant has been diagnosed as a sociopath. There was substantial doubt even as to that diagnosis.

H.C. 179-67, Exhibit B. Letter of October 24, 1962; 1962 Trial Tr. 10-11. This personality disorder is on the borderline of mental illnesses. Many do not believe that it is a mental illness at all. 1967 Hearing Tr. 402-03. The Mental Health Commission stated in 1965 that further hospitalization would hamper Appellant's further improvement and that he should be promptly released.

The plain fact is that Appellant would never have been committed to St. Elizabeths at all if his mother and the attorney she retained had not agreed, without his consent, to argue that he was insane at the time of the offense charged.

4. This Court has invited inquiry, for the first time, into the degree of danger which the patient would present. Appellant submits that the danger to society from his release would be non-existent or minimal. Cf. Millard v. Cameron, ____ U.S. App. D.C. ____ No. 19,584, decided October 10, 1966.

There was testimony in the remand hearing from Dr. Clarence Bunge, a member of the Mental Health Commission, which reaffirmed his testimony in the 1965 Hearing that Appellant would not pose a danger of any sort to society if he were released. 1967 Hearing Tr. 287-88.

Furthermore, as noted above, the Mental Health Commission itself had recommended Appellant's release from the Hospital in 1965. The undisputed evidence is that Appellant's condition has improved since that time. 1967 Hearing Tr. 114.

Also in the 1965 hearing, Dr. Albert Marland testified that Appellant's possession of a gun had been an isolated incident, unlike any of his other activities. Tr. 54-55. He stated that release would pose little risk to the community. Ibid. Dr. Marland's view is buttressed by the fact that Appellant's record does not show a single act of violence of any kind, before or after his commitment to St. Elizabeths.

Dr. Israel Zwerling, who testified in the remand hearing, indicated that there was a possibility that Appellant might make purchases for which he did not have adequate funds or commit other acts of like nature. Zwerling Dep. 74-75. He stated explicitly, however, that Appellant did not pose a danger to the community in the sense that he might commit violent acts. Ibid.

The only suggestion that Appellant might be a more substantial threat to society came in the 1965 Hearing.

Under intense cross-examination by the judge, Dr. Economon conceded that there was a possibility that Appellant might get a gun and shoot someone. 1965 Hearing Tr. 21-22. This speculation was not repeated at the 1967 Hearing. Cf. 1967 Hearing Tr. 405. Appellant urges that this stale conjecture as to what Appellant could perhaps do at some future date, made under sharp questioning by the judge, is not entitled to substantial weight at the present time. It is totally contradictory to all other expert testimony in the case, and it is inconsistent with the fact that the record does not show a single instance of Appellant engaging in a violent activity.

* * * * *

In addition to the above considerations, suggested by this Court, Appellant calls attention to these additional facts which militate in favor of his immediate conditional release:

1. Appellant is now 22 years old. He is a high school graduate and has taken and passed a number of correspondence courses while in the Hospital. Psychiatric Notes, August 5, 1966. His intelligence level is very superior. Psychiatric Notes, Psychological Summary, November 21, 1962, p. 2. If he is to have an opportunity to go to college and complete his education, he must have that opportunity promptly.

2. The Mental Health Commission has stated that further hospitalization is deleterious. Dr. Bunge so testified in the 1967 Hearing. Tr. 288. Appellant will accept any reasonable conditions, relating to out-patient psychiatric treatment or otherwise, suggested by the Hospital.

3. The crime with which Appellant was originally charged was a misdemeanor. The legality of his arrest was questionable and the evidence against him was probably inadmissible. If he had been

adequately advised at his original hearing, there is a strong possibility that he would not have been deprived of his liberty at all.

4. The showing of inadequate treatment made by Appellant in the Court below was made despite the judge's constant interruptions, unreasonable limitations on the presentation of Appellant's case, and frank hostility. See infra, pp. 105-19.

5. Appellant submits that the Hospital has a weightier burden of establishing the adequacy of treatment under the circumstances of the instant case and the factors enumerated above. A showing of adequate treatment that would be sufficient in a situation where a dangerous felon was seeking release should not be regarded as a sufficient showing in this case.

In summary, Appellant contends that a conditional release should be ordered immediately in this case.

In the event that the Court concludes that the treatment afforded Appellant was inadequate but that immediate conditional release is not appropriate, Appellant

requests the Court to order Appellant's release in the event that the Hospital doe not commence within a reasonable time an adequate treatment profram for Appellant, specifically tailored to his needs.

III. IF THE RELIEF REQUESTED BY THE PRECEDING SECTIONS
IS DENIED, APPELLANT IS ENTITLED TO A NEW HEARING
ON THE ADEQUACY OF THE TREATMENT AFFORDED TO HIM

By reason of the judge's erroneous rulings on matters of law, his disregard of this Court's remand opinion, his arbitrary limitations on the presentation of Appellant's case, his continual interruption of Appellant's counsel, and his frank hostility, Appellant was denied a fair hearing and a reasonable opportunity to rebut the government's argument that the treatment afforded him was adequate.

A. The Judge Erred in Denying Appellant
an Opportunity To Take the Depositions
of Hospital Staff

In advance of the remand hearing Appellant filed a Notice that he intended to take under the Federal Rules of Civil Procedure, the depositions of the St. Elizabeths psychiatrists most closely involved with Appellant and of the supervising attendant on Appellant's ward. Appellee moved to quash Appellant's Notice of Deposition.

A hearing was held on the Appellee's Motion to Quash before Judge Holtzoff on December 6, 1966, at which Appellant's counsel made clear that the depositions could be taken at the convenience of the Hospital staff. Deposition Hearing Tr. 18; Motion for Clarification of Remand Order in Rouse v. Cameron, No. 19,863, p. 11. After hearing argument, the court granted the Appellee's Motion on the ground that permitting the depositions would be oppressive and unduly burdensome to the Hospital staff. Deposition Hearing Tr. 17.

Appellant filed a Motion for Clarification of Remand Order in this Court, arguing that the action of the District Court appeared to be inconsistent with this Court's order remanding the case for full development of the treatment question.

This Court in a per curiam order (one judge dissenting), stated:

"It appearing that depositions would provide material assistance to the indigent movant's expert witnesses and thereby facilitate the full exploration of the issues regarding treatment contemplated in our opinion; that the order

quashing the notice of deposition may be 'responsible for the failure of . . . [the indigent movant] to prove . . . [his] case,' 4 Moore, Federal Practice ¶ 26.37, at p. 1761 (1963), and thereby 'unduly prejudice' him, Roebling v. Anderson, 103 U.S.App.D.C. 237, 243, 257 F.2d 615, 621 (1958); and that therefore said order may be vulnerable to attack on review of the remand proceedings, and;

"It further appearing, however, that it would not be appropriate to grant the extraordinary relief presently sought, it is

"ORDERED by the court that the motion be, and hereby is, denied."

Appellant contends that he was severely prejudiced by the denial of an opportunity to take depositions, and that the District Court's erroneous ruling substantially impaired his ability to establish the inadequacy of the treatment afforded him.

The availability of depositions to the petitioner in a habeas corpus proceeding is no longer in doubt. Although the judge below reserved judgment on this question while passing on the Motion to Quash, he ruled during the course of the remand hearing that depositions are, as a matter of law, available to a petitioner in a habeas corpus case. 1967 Hearing Tr. 121. This Court's order of December 29,

1966, is plainly based on the premise that petitioner in a habeas corpus proceeding can avail himself of the deposition procedure. See also Seals v. Wiman, 304 F.2d 53 (5th Cir. 1962).

Appellant had submitted a number of affidavits in support of his Notice of Deposition. One of Appellant's co-counsel submitted an affidavit stating that an opportunity to take the depositions sought was essential to the adequate preparation of Appellant's case on remand. Motion for Clarification, Affidavit of Edward E. O'Neill, ¶¶ 3-6. Appellant also submitted affidavits of two expert psychiatrists who stated that the kind of detailed knowledge of Appellant's treatment which could be developed through depositions would be extremely useful in the preparation of psychiatric testimony, particularly since the Hospital claimed to be providing milieu therapy. Motion for Clarification, Affidavits of Dr. Irving Schneider and Dr. Simon Auster. The government did not submit any evidence in support of its Motion to Quash.

That Appellant was in fact prejudiced by his inability to take depositions is clear from the record. Much of the

testimony on milieu therapy at the remand hearing represented a great departure from past Hospital testimony on this subject. Compare testimony of Dr. Economon in the 1965 Hearing, Tr. 36-38, which suggested that mere presence in John Howard was sufficient therapy, with his testimony at the 1967 Hearing, Tr. 101-19, 135-88. Appellant was handicapped in his ability to respond to such new matter. Moreover, Appellant's expert witnesses were denied the opportunity to study in advance the details of Appellant's alleged treatment. While they were still able to offer expert opinions, one of them was unable to form an opinion on a central issue (Kraft Dep. 19), and the judge explicitly discounted the testimony of the other on the ground that he did not have sufficient information. 1967 Hearing Tr. 415. Appellant's entire effort to establish the inadequacy of treatment was impaired by the fact that he did not know in advance what the Hospital's claims of treatment were to be.*/

*/ The problem was aggravated by the judge's ruling at the hearing that Appellant had the burden of going forward with the evidence. See, infra, 102-04.

Depositions in the context of this hearing would have been particularly useful. Under Rule 26(b) of the Federal Rules of Civil Procedure, depositions may be used to discover material inadmissible at trial and to inquire into matters which may produce usable evidence. In this case facts could have been elicited which would permit the issues to be clearly and sharply drawn at trial. In the end, there would probably have been a net saving of time to the district court, the St. Elizabeths staff, and Appellant's experts. In addition, a more satisfactory record could have been made.

The trial judge based his decision to quash the Notice of Depositions on the fact that depositions would be too onerous and burdensome to the government. Especially since Appellant's counsel had stated their willingness to take the depositions at the convenience of the Hospital personnel, the judge's granting the Motion to

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Quash was an abuse of discretion.

*/ See San Souci v. Schmidt, 282 F.2d 833, 836 (D.C. Cir. 1960) (need for proof of unreasonable oppression); Goldberg v. Raleigh Manufactureres, Inc., 28 F. Supp. 975, 977 (D.Mass. 1939) ("The mere fact that the plaintiff would be required to attend the examination and thereby absent himself from some of his usual business affairs during the taking of a deposition is utterly insufficient to justify the Court in ruling that he is being annoyed, embarrassed, or oppressed . . ."); 2A Barron & Holtzoff, Federal Practice and Procedure § 715.1, at 239 n.92 ("As long as witnesses knew facts material to issues in suit or which would lead to discovery of material facts their interrogation was proper, notwithstanding fact that they were busy men in industry. Frasier v. Twentieth Century-Fox Film Corp., D.C.Neb. 1958, 22 F.R.D. 194. In action by Price Administrator to enjoin defendants from selling clothing at prices in excess of maximum price established by regulations, an examination of enforcement attorney, associated with plaintiff's attorney, regarding evidence procured from defendants and on which administrator relied as foundation for action could not be denied on ground that enforcement staff was too busy to spare time involved in such examinations. Bowles v. Ackerman, D.C.N.Y. 1945, 4 F.R.D. 260"): Barron & Holtzoff at 252 n.19 ("annoyance or embarrassment or oppression must be unreasonable to move the court to grant relief . . . Objection that examination would constitute inconvenience and annoyance to Government personnel was not sustained. Kaiser-Fraser Corp. v. Otis & Co., D.C.N.Y. 1951, 11 F.R.D. 50"); cf., United States v. Howard, 360 F.2d 372, 381 (3rd Cir. 1966) (U.S. need not answer interrogatories designed merely to harass U.S.); Capitol Vending Co. v. Baker, agency has some knowledge of subject matter before he will be ordered to testify on deposition). See generally, 4 Moore, Federal Practice §§ 26.05, 30.06 (1963).

B. Appellant Was Substantially Prejudiced by the
Judge's Decision To Impose the Burden of Going
Forward with the Evidence on Appellant

As noted above, pp.57-58 , Appellant contends that the judge erred in imposing on him the burden of proving the inadequacy of the treatment afforded to him. Appellant further contends that the judge erred in imposing upon him the burden of going forward with the evidence. On the latter ruling, the judge changed his position in the middle of the hearing. The government began to present its evidence to establish that the treatment afforded petitioner was adequate. The government put on Dr. Cameron and Dr. Straty Economon, Appellant's ward administrator. The first day of hearings recessed with Dr. Economon on the witness stand. When the hearings reconvened, Judge Holtzoff announced that he was reversing the order of proceeding and that the burden of going forward with the evidence, as well as the burden of proof, would be on the Appellant. 1967 Hearing Tr. 131-32.

Since Appellant could not present any evidence on the adequacy of the treatment afforded until the Hospital psychiatrists had presented evidence establishing what they claimed treatment was, Appellant was in the untenable position of

having to establish through the Hospital psychiatrists what treatment the Hospital claimed it was providing. As a matter of logic and orderly procedure, requiring the Appellant to go forward is simply indefensible. If depositions are denied to a petitioner, the only way he can inform himself of the claimed treatment is by listening to the government's witnesses in open court.

Since Dr. Economon had already testified at some length, counsel for Appellant requested leave to cross-examine him. 1967 Hearing Tr. 133. Appellant's request to cross-examine was denied and the court gave Appellant leave to call Dr. Economon as his own witness. Thus, Appellant never had an opportunity to cross-examine the government's key witness.

Aside from the patent unfairness of this procedure, which required Appellant to make the government's case for it, the judge refused to permit counsel to control the examination. Dr. Economon, in particular, frequently answered questions with florid and verbose speeches that were unresponsive to the questions put and extremely prejudicial to Appellant. See, e.g., 1967 Hearing Tr. 133-53. The court refused to permit counsel to hold his own witness to the questions he asked

him. A typical exchange between Appellant's counsel and Dr. Economon was as follows:

Q. Is ward 11 used as a place to put patients who misbehave on other wards?

A. I don't wish to quibble, but again I don't know what you mean by misbehave.

Perhaps in my own words I can answer the question that you are seeking to ask.

Q. Let me rephrase the question.

THE COURT: Let the witness finish. You may finish your answer.

1967 Hearing Tr. 143.

The witness's answer to the question which he posed to himself ran for a page and a half. Appellant's counsel's objections to Dr. Economon's lengthy and unresponsive answers were unavailing. See 1967 Hearing Tr. 139-51. The culmination of Dr. Economon's uncontrollable speech-making came in response to counsel's question relating to the treatment plan of Appellant, which Dr. Economon had testified he carried in his head. Id. at 154. Dr. Economon's answer ran for nine unresponsive pages. Id. at 155-63.

C. The Judge's Overt Hostility to Appellant's
Legal Position Made It Impossible for Appellant
To Have a Full and Fair Hearing on the Adequacy
of His Treatment

Throughout the proceeding below, the judge made it perfectly plain that he considered the hearing a pointless imposition on his time. At the deposition hearing, for example, he asked rhetorically:

"Now, how can a layman and a judge as a layman determine how much treatment should be given to a hospital patient?

"For example, I could not determine the question as to what is the best medicine for a cold." Deposition Hearing, p. 13.

He likened the proceeding to one in which "the courts will have to determine whether a particular patient needs a gall bladder operation and instruct the doctor whether to operate or not." 1967 Hearing Tr. 343. This attitude of dismay as to what Appellant and this Court were asking him to consider pervaded the hearing.

On a number of occasions the judge stated that he thought he could not properly grant any of the relief which Appellant sought and which this Court had stated was appropriate. See 1967 Hearing Tr. 55, 124, 211, 340, 341, 343. An unwillingness to follow this Court's ruling, as understood by

Appellant, seemed apparent in many of his remarks. See, e.g., 1967 Hearing Tr. 58. For example, he stated that he considered the shortage of staff at St. Elizabeths "irrelevant" to the hearing. 1967 Hearing Tr. 55. He even stated that a showing that John Howard was inadequately staffed to provide milieu therapy would not lead him to conclude that Appellant was not receiving adequate treatment. Id. at 124-25.

The judge's attitude had a chilling effect on Appellant's counsel's efforts to establish the inadequacy of the treatment afforded to Appellant, and provided the unifying thread which wove together many seemingly arbitrary and unreasonable rulings and interventions in the trial proceedings.

The judge stated and restated that it was essential to bring the hearings to the speediest possible conclusion. On the first day of hearings, he stated that he wanted the case completed by the noon recess. 1967 Hearing Tr. 3. His admonitions to speed the trial along were frequently reiterated to Appellant's counsel thereafter, often coupled with suggestions that counsel terminate his examination or cross-examination of a witness. 1967 Hearing Tr. 58, 64, 69, 72, 73, 74, 101, 111, 218, 295.

The judge was also at pains to show that he considered the hearing an unimportant matter which imposed on the court's time. He stated that he "would rather save the court's time for cases that are important." 1967 Hearing Tr. 122. When Appellant's counsel asked a Hospital psychiatrist how much of their time is spent in court, the judge quipped, "Well, probably an awful lot is spent because lawyers like you make it necessary." 1967 Hearing Tr. 53. See also 1967 Hearing Tr. 55.

In the same vein, the judge criticized Appellant's counsel's "attitude in making a cause célèbre out of an ordinary habeas corpus case." 1967 Hearing Tr. 125. At the bench he interrogated Appellant's counsel on the reason for the large number of spectators in the courtroom and asked whether he had notified reporters. ^{*/} Ibid.

The judge also stated that he did not want the hearing to be used as a vehicle for criticizing St. Elizabeths Hospital, and he cautioned Appellant's counsel not to introduce any

*/ Government counsel admitted that he had mentioned the case to a reporter during the previous month. Id. at 127.

testimony that might be taken as an attack on the Hospital. While Appellant had no interest whatsoever in attacking the Hospital, the judge's repeated cautions made it more difficult to develop Appellant's position on the adequacy of the treatment he was afforded in the Hospital.* / 1967 Hearing Tr. 124, 127.

D. The Judge's Limitations on the Evidence Appellant Could Present, Limitations on His Direct and Cross-Examination, and His Frequent Interruptions Unreasonably Restricted His Ability To Prove His Case

1. Limitations on Evidence

In advance of the hearing the judge limited to two the number of expert witnesses to be called by Appellant on the treatment question. 1967 Hearing Tr. 123, 217. By so limiting Appellant's case, he substantially impaired Appellant's effort to show that there was a consensus among the leaders of the profession as to the prerequisites of an adequate milieu

* / The judge interrupted Appellant's counsel's examination of his expert witness to suggest that his questions might embarrass the witness by asking him to offer a judgment on the adequacy of the treatment provided by another doctor. Id. at 206-07. The witness had theretofore stated that he was prepared to offer such an opinion. Ibid.

therapy program. In his decision the judge stated that no generally accepted standards had been established to his satisfaction. 1967 Hearing Tr. 411. Appellant submits that the judge's arbitrary limit on the number of expert witnesses accounted in large part for any inadequacy in the clarity of the standards as established at the hearing. ^{*}/ In a hearing going for the first time into an area of adequacy of treatment, such a limitation on the number of expert witnesses was unwarranted and capricious. Indeed, this Court's remand decision plainly called for a broad hearing in which the fullest use would be made of expert testimony. Rouse v. Cameron, Slip opin., pp. 10-11.

^{*}/ Appellant's counsel had obtained commitments from Dr. Jack Ewalt, Director of Massachusetts Mental Health Center and Bullard Professor of Psychiatry at Harvard Medical School; Dr. Alfred Stanton, Psychiatrist-in-Chief at McLean Hospital, Belmont, Massachusetts and Associate Professor of Psychiatry at the Harvard Medical School; and Dr. Herbert Modlin, Senior Psychiatrist and Director of the Law and Psychiatry Division at the Menninger Foundation, Topeka, Kansas, to testify on the adequacy of the treatment afforded to Appellant. The judge's ruling, prior to the hearing, that only two expert witnesses could be called by Appellant on adequacy of treatment made it necessary for counsel to cancel these commitments. This ruling thus substantially diminished the range of testimony presented in the hearing.

2. The Judge Erred in Refusing to Permit
Appellant's Expert Witnesses to Offer
Live Testimony in Open Court

Throughout the hearing, the judge frequently interrupted the examination and cross-examination of witnesses by Appellant's counsel without objection from government counsel. Government counsel seemed willing to permit the hearing to proceed in an orderly fashion with a full airing of the complex issues involved. The judge's constant intervention made this impossible.

A striking example of the judge's unreasonable interference with Appellant's presentation of his case was in the examination of Dr. Alan Kraft. Dr. Kraft, Director of the Fort Logan Mental Health Center in Denver, Colorado, Assistant Professor of Psychiatry at the University of Colorado Medical School, and a nationally recognized expert on milieu therapy, was called as a key witness for the Appellant on the question of the adequacy of treatment. Dr. Kraft had personally interviewed Appellant, had carefully studied Appellant's hospital records, and had heard the testimony of St. Elizabeths personnel concerning Appellant's treatment. It is uncontradicted in the record that Dr. Kraft was able to form an

opinion on the adequacy of the treatment afforded Appellant on the basis of this information, 1967 Hearing Tr. 206, 208, 212, and Dr. Kraft was prepared to state that opinion. But the judge, with a tattoo of sua sponte objections, refused to permit him to testify in open court. 1967 Hearing Tr. 198-217.

The judge interrupted the examination of Dr. Kraft each time he was asked to state his opinion on an issue pertinent to the hearing. The various grounds stated for these rulings were technical in the extreme. They contradicted in spirit the statements of this Court in Lake v. Cameron, ____ U.S.App. D.C. ____, ____, 364 F.2d 657, 660-61 (1966), that the technicalities of the ordinary adversary proceeding should be suspended in a mental health case. Although the judge had himself in the 1965 Hearing stated, "We don't enforce the rules of evidence strictly," Tr. 51-52, and had acted on that principle, his antagonism to Appellant's position in the 1967 Hearing led him to impose the most stringent technical restrictions, without prompting from government counsel, on Appellant's counsel's attempts to elicit testimony.

Even assuming, arguendo, that the judge was entitled to insist sua sponte upon the minutest detail of the rules of evidence -- which was plainly improper under the circumstances, Lake v. Cameron, supra, -- he still erred as a matter of law in his rulings obstructing the testimony of Dr. Kraft.

The District Court repeatedly asserted that no proper predicate had been laid for Dr. Kraft's opinion testimony and insisted that either a hypothetical question be formulated, 1967 Hearing Tr. 208, 254, or "a summary of the treatment concerning which" Dr. Kraft was to testify be presented. Id. at 211. There is no support for the exactions which the court demanded as a prerequisite to the doctor's testimony. It is well settled that expert opinion may be based upon the predicates stated by petitioner's counsel below -- i.e., the doctor's interview with Appellant, his hearing of the testimony of other witnesses, and his review of Appellant's records. There is no need to recapitulate the underlying information by means of a summary or hypothetical question. The rule is firmly established that an expert may use hospital records, whether or not those

records are in evidence, as a basis for his expert opinion. United States v. Cannon, 116 F.2d 567, 569 (1st Cir. 1941); Travelers Insurance Company v. Childs, 272 F.2d 855, 857 (2d Cir. 1959); Birdsell v. United States, 346 F.2d 775, 779 (5th Cir. 1965); Fitts v. United States, 328 F.2d 844, 847 (10th Cir.) cert. denied, 379 U.S. 851 (1964).

The leading case in this circuit is Jenkins v. United States, 307 F.2d 637 (D.C. Cir. 1962) (en banc), where the court held that the district court's exclusion of a medical expert's testimony was reversible error. There, as in this case (see 1967 Hearing Tr. 206, 208, 212), the witness testified that he could arrive at a valid opinion on the basis of certain records and his own examination of the patient. This Court held that the expert's testimony could properly be predicated upon reports not in evidence which were of the type upon which he normally relies in reaching such opinions. A fortiori, where, as here, the reports to be relied on are evidence in the case, there is no basis for excluding the expert's opinion. The judge -- who was the sole trier of the facts -- should have let him be heard. See also Alexander v. United States, 318 F.2d 274, 275 (D.C. Cir. 1963).

Dr. Kraft also attempted to offer testimony predicated upon the factual testimony of other witnesses, which explained the treatment afforded to Appellant. It is not disputed that Dr. Kraft was present throughout all the hearings. 1967 Hearing Tr. 202. Nevertheless, the court ruled that "it is incompetent for an expert witness to give expert opinions on the basis of the testimony that he hears." 1967 Hearing Tr. 254. This is plainly not the law. In Blunt v. United States, 244 F.2d 355, 364 (D.C. Cir. 1957), this Court unequivocally stated that an expert's "opinions may be based on facts he has himself observed, or facts he has heard others relate, or hypothetical facts presented to him." [Emphasis supplied.] In a footnote appended to the phrase underlined in the preceding sentence, the court noted that "[t]he psychiatric witnesses were permitted to be present during the testimony of the other witnesses." 244 F.2d at 364, n.24. Thus, it cannot be doubted that previous testimony may serve as a proper basis for an expert's opinion. ^{*/}

*/ The District Court's rationalization that "testimony is sometimes contradictory" (1967 Hearing Tr. 202) is meaningless in the context of the case. There is no conflict in the testimony on which Dr. Kraft's opinion was predicated. Cf. 2 Wigmore, Evidence § 681. Nor is it a satisfactory excuse

(Footnote continued)

Furthermore, at the deposition hearing, counsel for Appellant had urged the need to have a fuller development of the Hospital's treatment claims in order to provide a better predicate for Appellant's expert testimony. In quashing Appellant's Notice of Deposition, the judge stated that testimony at trial would fill in the gaps in information on the treatment afforded. Deposition Hearing Tr. 16, 17. The judge's ruling at trial that such testimony could not be taken into account by Appellant's experts was inconsistent with his own previous statement and placed an unreasonable burden on Appellant.

The other objections which the judge interposed to counsel's examination of Dr. Kraft are equally insupportable. This applies to the judge's assertion that Dr. Kraft could not offer an opinion on the doctor-patient relationship without speaking to the doctor (1967 Hearing Tr. 205); to

*/ (continued from previous page)
that "we don't know what he has heard." 1967 Hearing Tr. 201. In elaborating his opinion -- had he been allowed to give it -- Dr. Kraft would have made clear the specifics of treatment methods, or the absence thereof, which controlled his judgment. This would have given the court a sufficient basis for judging the doctor's evaluation in light of the testimony on which, in part, it was predicated.

his refusal to permit Dr. Kraft to give his expert opinion on a question of medical judgment, on the ground that it was ultimately for the judge's determination (1967 Hearing Tr. 202); to his refusal to permit Dr. Kraft to describe generally accepted hospital procedure (1967 Hearing Tr. 204); to his objection to the use of "technical terms" such as "therapeutic relationship" (Ibid.). All of these objections were interposed by the judge; the government was quite willing to have the examination proceed in an orderly manner.

After this unsuccessful effort to present Dr. Kraft's testimony, counsel for both parties agreed to proceed with Dr. Kraft and Appellant's other expert on treatment, Dr. Israel Zwerling, by deposition. See 1967 Hearing Tr. 252-53. While Dr. Kraft's and Dr. Zwerling's depositions were placed in the record, Appellant was unreasonably denied the right to present live expert testimony on the central issue in the case. Moreover, Appellant's counsel's examination of Dr. Kraft and Dr. Zwerling was greatly impaired by his efforts to stay within the bounds of the judge's technical and erroneous rulings on points of evidence. In addition, the judge excluded from his consideration parts of the depositions on the basis of his erroneous evidentiary rulings.

3. The Judge Unreasonably Restricted Appellant's Examination and Cross-Examination on the Central Issues in the Case

The judge objected sua sponte to many of Appellant's counsel's efforts to explore some of the central issues in the case. For example, he refused to permit a question to Dr. Cameron about the Hospital's present goals in staffing requirements for John Howard. 1967 Hearing Tr. 60. He refused to permit questions to explore the extent of time John Howard psychiatrists have available for treatment. 1967 Hearing Tr. 264.

By his insistence that Appellant's counsel restrict his inquiry, in the narrowest terms, to the particular patient, he foreclosed a number of fruitful inquiries. 1967 Hearing Tr. 130-31, 264. For example, a comparison of the staffing and treatment facilities in other St. Elizabeths services with the staffing and facilities of John Howard was precluded.

The judge was particularly restrictive of Appellant's efforts to establish the character of ward life and ward routines, the most essential material for the analysis of milieu therapy. Assignment to particular wards, for example, which Dr. Economon considers a matter of critical importance in

milieu therapy, 1967 Hearing Tr. 18-21, was dismissed by the judge as "a professional and administrative matter" and a "waste of time" for the courts. 1967 Hearing Tr. 267.

On the nature of milieu therapy itself, the judge would not permit Appellant's counsel to cross-examine Dr. Cameron, who held out this mode of therapy to be the primary therapy available to Appellant. 1967 Hearing Tr. 73.

In addition to these arbitrary limitations on the subjects covered, the judge constantly interrupted the continuity of Appellant's counsel's examinations with self-generated objections. For example, the judge excluded a question of Appellant's counsel because it used the term "therapeutic team," which he considered inappropriate. 1967 Hearing Tr. 277.

(However, the judge had not objected to the use of the same term by Dr. Cameron. 1967 Hearing Tr. 21.) He objected to the use of the term "belief" instead of "opinion," id. at 261, to the use of the term "identify" instead of "describe," id. at 203-04. These objections, coupled with his frequent urgings to speed the proceedings along, made it impossible to conduct a thorough and careful examination.

The handicap under which the Appellant labored is seen most clearly when contrasted to the judge's

treatment of government counsel. The judge let him conduct the most wide-ranging inquiries into treatment philosophies and practices, whether or not they pertained to Appellant. For example, the judge permitted, over objection, testimony on the Hospital's future building plans. 1967 Hearing Tr. 23-24. Moreover, he permitted the Hospital psychiatrists, whether called by the government or Appellant, to make rambling speeches that often wandered far from the question of the treatment of Appellant. See, especially, 1967 Hearing Tr. 101-19, 134-88.

For the reasons indicated in the above sections, Appellant respectfully requests that No. 20,881, if it is remanded for further hearings, be set before a different judge. See Salley v. U.S., 122 U.S. App. D.C. 359, 353 F.2d 897 (1965), and cases cited therein.

CONCLUSION

For the reasons stated herein, Appellant requests this Court to reverse the District Court's decision in H.C. 179-67 (No. 20,962) and order Appellant's immediate release from the custody of Appellee.

In the event that this relief is denied, Appellant requests this Court to reverse the decision of the District Court in H.C. 287-65 (No. 20,881) and order Appellee to grant Appellant a release on such reasonable conditions as the Hospital deems appropriate. If this Court concludes that immediate conditional release is not warranted, Appellant requests this Court to order Appellant's release 30 days hence if a suitable treatment program is not initiated before that time.

In the event that this Court remands H.C. 287-65 for further hearings, Appellant requests that such hearings be held before a different judge.

Respectfully submitted,

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May 17, 1967

BRIEF AND APPENDICES FOR APPELLEE

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20,881

CHARLES C. ROUSE, APPELLANT

v.

**DALE C. CAMERON, SUPERINTENDENT, SAINT ELIZABETHS
HOSPITAL, APPELLEE**

No. 20,962

CHARLES C. ROUSE, APPELLANT

v.

**DALE C. CAMERON, SUPERINTENDENT, SAINT ELIZABETHS
HOSPITAL, APPELLEE**

APPEAL FROM THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

United States Court of Appeals

for the District of Columbia Circuit

FILED JUL 3 1967

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QUESTIONS PRESENTED

In the opinion of appellee, the following questions are presented:

Whether a patient committed to a mental hospital in a criminal proceeding pursuant to 24 D.C. Code § 301(d) has a statutory right to psychiatric treatment created by the 1964 revision of the District of Columbia statutes relating to civil commitments and civilly committed patients in 21 D.C. Code § 562.

Whether a patient so committed has a constitutional right to psychiatric care and treatment beyond that which is sufficient to differentiate therapeutic facilities from penal institutions.

Whether 21 D.C. Code § 562 or the Constitution requires the courts to inquire into whether a particular patient in a mental hospital is receiving psychiatric treatment which is adequate in the light of present medical knowledge, or whether the allocation of public resources both within and without the hospital is a matter for the hospital authorities, in the exercise of sound medical discretion, and for the Congress, and thus beyond the proper function of the judicial branch.

Whether, if a court should so inquire into the adequacy of psychiatric treatment, its inquiry should go beyond a determination that a *bona fide* effort is made to afford treatment appropriate to the patient's needs.

Whether any inquiry into the adequacy of a patient's treatment should be made *in vacuo*, without considering his need for treatment in the context of the effect upon the public safety of his improvident release.

Whether appellant in fact received treatment so inappropriate to his needs or so inadequate in the light of modern medical knowledge that he should be released.

Whether the trial judge so crippled appellant's presentation of his voluminous case on the adequacy of his treatment that a new and longer hearing below is required.

IV

Argument—Continued

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 20,881

No. 20,962

CHARLES C. ROUSE, APPELLANT

v.

DALE C. CAMERON, SUPERINTENDENT,
SAINT ELIZABETHS HOSPITAL, APPELLEE

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

BRIEF FOR APPELLEE

COUNTERSTATEMENT OF THE CASE

These are consolidated appeals from two orders of the District Court dismissing petitions for *habeas corpus* and remanding appellant to Saint Elizabeths Hospital.¹

The first appeal, No. 20,881, arises out of the hearing held before Judge Holtzoff in January, 1967 in H.C. No. 287-65 on remand from a prior appeal, No. 19,863.² At that hearing, the

¹ There are four transcripts before the Court. They are herein cited as follows: (a) "T. Tr." refers to appellant's trial in the Municipal Court in November 1962; (b) "1 Tr." refers to the first hearing in H.C. No. 287-65 before Judge Holtzoff on September 13 and November 1, 1965; (c) "2 Tr." refers to the second hearing in H.C. No. 287-65 on January 9, 12, 16 and 17, 1967; (d) "3 Tr." refers to the hearing before Judge McGarraghy in H.C. No. 179-67 on April 24, 1967. There are also two depositions submitted in H.C. No. 287-65, which are cited according to the name of the deponent, as "Zwerling Dep." (occasionally "Z. Dep.") and "Kraft Dep." (sometimes "K. Dep.").

² *Rouse v. Cameron*, — U.S. App. D.C. —, 373 F. 2d 451 (1966) (hereinafter *Rouse I*).

court ruled that appellant, who was mandatorily committed to the Hospital under 24 D.C. Code § 301(d) on November 9, 1962, by the then Municipal Court after being found not guilty by reason of insanity on a charge of carrying a pistol without a license,² had failed to establish his eligibility for release. The court held both that appellant had not sufficiently recovered to merit release and that appellant was "receiving treatment which is adequate according to proper standards,"⁴ and thus was not entitled to his release or any other appropriate relief on the novel ground of lack of treatment first judicially recognized in his first appeal, *Rouse I*.

The second appeal, No. 20,962, arises out of another *habeas* proceeding, H.C. No. 179-67, in which appellant unsuccessfully contended that his commitment to Saint Elizabeths was invalid *ab initio*, either because it was not authorized by § 24-301(d) or because that statute could not constitutionally apply to him.

This Court granted appellant's motion to consolidate his appeals on May 11, 1967 and then, on May 17, 1967, *sua sponte* ordered the consolidated appeals to be heard *en banc*, 28 U.S.C. § 46(c). That order indicated that "all issues previously considered and decided" in *Rouse I* "are open for reargument and reexamination."

The criminal case

Appellant was arrested by Pvt. Otis D. Bruce of the Metropolitan Police at about 1:45 a.m. on Friday, September 7, 1962. T. Tr. 3. Appellant was carrying "a small suitcase," *ibid.*, which contained the following: two electric drills; six drill bits; one hack saw; two hack saw blades; one 25-foot extension cord; one pair of leather gloves; a Colt .45 automatic pistol, 500 rounds of .22 ammunition, and 100 rounds of .45 ammunition.⁵

Appellant had purchased the .45, which was loaded, at a sporting goods store in Seven Corners, Virginia, T. Tr. 5, paying

² 22 D.C. Code § 3204.

⁴ 2 Tr. 416.

⁵ Schedule of Property filed with appellant's Motion to Suppress, September 15, 1962. This, like the other trial court documents cited and quoted in this portion of the Counterstatement, is included in appellee's Exhibit 1 in H.C. 287-65, and in appellant's exhibits in H.C. 179-67.

for it with a bad check, T. Tr. 19. Appellant, an eighteen-year-old white Virginian, was charged with Carrying a Deadly Weapon, i.e. a pistol without a license, 22 D.C. Code § 3204, in the Municipal Court for the District of Columbia that very day, September 7, 1962.

Appellant's appointed counsel, Samuel J. Ochipinti, Esq., filed a motion to suppress all the items taken from appellant on September 15. On the day that motion was set for hearing, September 21, James J. Laughlin, Esq. entered an appearance as retained counsel for appellant, and moved for his commitment to a mental hospital for examination under 24 D.C. Code § 301(a). Accompanying that motion was an affidavit by appellant's mother, set out in the margin.* The motion was granted and appellant was committed to D.C. General Hospital for thirty days on September 21.

On October 24, D.C. General reported that appellant was competent to stand trial, adding, however, the following paragraph:

Mr. Rouse has a very immature, passive-aggressive type of character structure which handicaps him in his ability to conform to the law. At this stage in his life, his act of carrying a dangerous weapon was, in our opinion the product of a mental illness. It is recommended that he be committed to a psychiatric hospital for further care and treatment.

After demanding a jury trial, Mr. Laughlin discovered that, although Rouse could post the \$300 bond set by the Municipal Court, detainers had been "lodged against him for alleged offenses committed in other jurisdictions." Accordingly, on November 7 Laughlin moved for "immediate hearing" on November 9, rather than a jury trial on November 26, referring to the

* Mrs. Harrison Rouse * * * deposes and says that she is the mother of the defendant Charles Rouse and that he has been acting strangely for a number of years and it is her belief that he is in need of psychiatric treatment. Affiant says that he has been getting into almost constant difficulty and his acts are of such a nature that no rational person would commit same. Affiant, after talking with others, is of the belief that he is suffering from a mental illness that can be described as Sociopathic Personality and she is of the belief that if he is under the hands of a competent psychiatrist his ailment will respond to treatment.

hospital report's conclusions and noting that if Rouse "suffers from a mental disability he should not be confined in the D.C. Jail."

The case came before Judge Andrew J. Howard, Jr., on November 9, 1962.

Private Bruce testified to his meeting with Rouse on September 7, identified the .45 Rouse had been carrying, stated it was loaded, and identified Rouse. T. Tr. 2-6. It was stipulated that Rouse had no "license to carry a gun," T. Tr. 5.

Dr. James Ryan, Associate Chief Psychiatrist of D.C. General Hospital, then testified to his opinion that Rouse suffered from a "chronic character disorder * * * of a sociopathic character," with "the additional diagnosis of a counterphobic neurosis." T. Tr. 10. He noted the change from "a passive-aggressive character" which "I recorded in the letter." *Ibid.* He stated the causal connection between this condition and Rouse's offense as follows, T. Tr. 11:

"One behavioral pattern which is frequently seen is carrying a gun * * * [I]n our diagnosis, in our evaluation we found that Mr. Rouse carried a gun out of fear, fear of attack, out of a feeling that he needed something additional to defend himself."

The offense was "a product of the disorder," T. Tr. 12. "Both of these conditions," *i.e.*, both the sociopathic character disorder and the counterphobic neurosis, "involve a weakening of control over aggressive impulse." *Ibid.*

On cross-examination, Dr. Ryan agreed with Mr. Laughlin that "constant conflict with the law, the inability to profit by the punishment meted out," is "one of the elements of a sociopathic personality," T. Tr. 13. He further agreed that Rouse "does not belong in a jail but * * * he should be in a psychiatric hospital," adding, as to whether Rouse "would respond to treatment," T. Tr. 14-15,

"I believe that this condition * * * is one which may— which may—change with psychiatric treatment. * * * He would have to be in the hospital for some period of time; I can say a good many months. It's hard to—to go beyond this. He's now eighteen and it would cer—

tainly be desirable for him to be in the hospital until it's clear that he has passed through the period of adolescence. * * * This would be a good many months."

As to whether, were Rouse "now released upon society, * * * he would likely to commit other offenses," Dr. Ryan had concluded that "he is presently a danger." T. Tr. 15.

The Government then rested "on the defense motion for mental observation."

Appellant's mother testified, T. Tr. 16-17, that

"he seems to have been at war with himself and with his family. * * * Seems to have absolutely no instincts for himself, for self-survival, no judgment. * * * [H]e's been rebellious and, in fact, unmanageable. Not always, but most of the time.

* * * * *

"[H]e has ran away from school and he gave checks then, and he's been taking things from his family and he has been in trouble before by going to the store and going into thousands of dollars worth of stuff. Of course, I got him out of that before."

She also stated that Rouse "gave a bad check for" the gun he was charged with carrying, and had "several charges," including one for that check, "pending in Virginia." T. Tr. 17. She agreed with Dr. Ryan that Rouse needed treatment, and could be "rehabilitated." He had "indicated his willingness to cooperate" in psychiatric treatment. T. Tr. 17-18.

Rouse himself then asked to take the stand, T. Tr. 18. In answer to Mr. Laughlin's questions, he admitted that this had not been his first arrest; ' that he had been unemployed at the time; and that he had paid for the gun with a bad check. T. Tr. 18-19. He refused to say why he had purchased the gun. T. Tr. 19.

Asked what he wanted to tell the court, Rouse said he had "not had a chance to talk to Mr. Laughlin," noting that Mr. Ochipinti had been "doing a fairly good job with me; at least, discussing what he was going to do." T. Tr. 20. He complained that "I wasn't given a chance to present to the Court" Mr. Ochipinti's motion to suppress evidence, and outlined his rea-

¹ Q: Now, * * * when was it you were arrested, sir?

A: Which time? This last time? (T. Tr. 18)

sons for thinking that motion would succeed. T. Tr. 20. In further questioning by Mr. Laughlin, Rouse agreed that he was "mentally sick" ("For [?from?] the stuff I have been doing, yes."), that he needed treatment, and that he had "indicated last week" that he "wanted to go to either D.C. General or Saint Elizabeths Hospital" rather than to jail. T. Tr. 20-21.

"I think I need treatment, but I also think that because of the charges I have pending out in Virginia on me now, that I would like to * * * clear this matter up here now and go over there and face those charges * * *." T. Tr. 21.

Mr. Laughlin then explained, "so there would be no dispute in the record," that

"I took it upon myself to waive any hearing on the motion to suppress because of the circumstances of his case, because our belief—the belief of the mother and my belief and Mr. Daly's belief—is that this man needs treatment. * * * The District Attorney was willing that that be argued, but I saw no purpose in it." T. Tr. 22.⁵

Mr. Laughlin then asked the court to commit appellant to Saint Elizabeths Hospital. Judge Howard asked "the purpose of this—this is a trial?" T. Tr. 23. Mr. Laughlin assured him that it was, stating that, on the issue of "the offense being a product of his mental disease under *Durham* and there being a causal connection, * * * he is entitled to a verdict of not guilty by reason of insanity." That verdict was then rendered, and appellant was accordingly committed to Saint Elizabeths Hospital pursuant to 24 D.C. Code § 301(d).

Confinement, group therapy, and prior proceedings

Rouse was admitted to the John Howard Pavilion, the maximum security service for male patients at Saint Elizabeths. He was originally admitted to Ward 5, from which he was transferred on November 26, 1962 to Ward 8. After a fairly extensive diagnostic work-up, a medical staff conference on February 21, 1963 arrived at a diagnosis of Sociopathic Per-

⁵ "Mr. Daly" apparently refers to the now Associate Judge of the Court of General Sessions, Hon. Edmond T. Daly, who in 1962 was Chief of the then Municipal Court Division of the United States Attorney's Office.

sonality Disturbance, Antisocial Reaction. He was then assigned to Ward 11, on the top floor of the building, a "secure" ward, on March 12, 1963. Except for a brief period in the Medical and Surgical Service, and a week on Ward 12 in January, 1964, he remained on Ward 11 until early 1965.

On June 19, 1963, Mr. Laughlin filed in the Municipal Court, which had become the Court of General Sessions, a motion requesting Rouse's "removal to George Washington University Hospital for treatment at the hands of a private physician." Attached thereto was an affidavit by Rouse's mother, stating that she had "engaged the services of Dr. Harvey H. Ammerman" for such treatment, following the completion of which Rouse could "then be returned to St. Elizabeths Hospital." After continuance to July 8, 1963, the motion was apparently denied.²⁸

On January 7, 1964, Rouse swore out his first petition for *habeas corpus*, H.C. No. 28-64. He stated he felt "that I am now well enough to be released to my detainer," referring to a Virginia warrant "charging me with worthless checks." He asked for release to have "a quick and speedy trial" on those charges. The Hospital's return, as usual, stated the basis for his commitment and the hospital staff's opinion that he was ineligible for release. But the return also noted that Rouse had attempted to defraud "a Radio and Electric Company in New York" of \$295.51 worth of merchandise, some of which had been delivered to him at the Hospital, and sent back to the New York concern on January 6, the day before the petition. Rouse eventually withdrew his petition without a hearing, on March 9, 1964.

On June 16, 1964, counsel previously appointed for Rouse in H.C. No. 28-64 filed a new petition, H.C. No. 232-64. This petition alleged only that Rouse had recovered and was entitled to his release. The Hospital's return traversed those allegations. After a hearing on June 22, 1964, Judge Hart found that Rouse had not recovered, and ordered his petition dismissed. The Hos-

²⁸ The motion and affidavit are included in appellee's Exhibit 1 in No. 20,881. The notations on the Information, which is in both that Exhibit and appellant's Exhibit B in No. 20,902, reveal no disposition of the motion, which may merely have been withdrawn.

pital records indicate that Dr. Charles F. Agler, the petitioner's ward psychiatrist, testified at the hearing.

Dr. Agler soon thereafter left the Hospital, but not before recommending that Rouse be afforded psychotherapy, particularly individual therapy. This recommendation bore fruit, and, on July 14, 1964, the day Dr. Agler's successor, Dr. Straty H. Economon, began work at the John Howard Pavilion, Rouse began group psychotherapy with a clinical psychologist, Dr. John F. Borriello. This group of six patients met twice a week in sessions an hour and a half long. 2 Tr. 176.

While Rouse was in group therapy with Dr. Borriello, Dr. Economon suggested changing his treatment by moving him "to a less secure ward, one with increasing privileges but also increasing responsibilities." 1 Tr. 12; 2 Tr. 179. Rouse "vigorously opposed" this, and once it was effected, Rouse became "so anxious, so upset, that it was necessary to transfer him back" to Ward 11. 1 Tr. 12.⁹

On February 16, 1965, Rouse "announced" to Dr. Borriello and the psychotherapy group that he was terminating group therapy after the next session, on the 18th. Dr. Borriello's contemporaneous note in the Hospital record states that, "When this premature termination was discussed with him, he stated that he preferred to remain the same because he did not want to experience the discomfort that is necessary for change to occur." ¹⁰

It was at about this time, or a little earlier, that Rouse obtained legal assistance, as Edward E. O'Neill, Esq., of the Legal Aid Agency began to negotiate with the Hospital authorities on his behalf in January, 1965. 1 Tr. 77-79. Mr. O'Neill apparently sought to get Rouse transferred "off service," i.e., out of the maximum security building. Dr. Economon thought such a transfer inappropriate, as "the boy showed no cooperation." 1 Tr. 78. Rouse "was transferred downstairs" during these negotiations, but not "to the West Side [Service]." 1 Tr. 79.

⁹ The Hospital records show that Rouse was transferred from Ward 11 to Ward 8 on January 7, 1965, and back to Ward 11 on January 29, 1965.

¹⁰ This note is included in appellant's Exhibit 1, the records kept by the hospital on appellant, a great part of which has been included in the record here in Xeroxed form. See also Dr. Borriello's testimony at 2 Tr. 278.

Round One of H.C. 287-65

Mr. O'Neill subsequently, on June 23, 1965, filed Rouse's third *habeas corpus* petition, H.C. No. 287-65, alleging that Rouse's confinement was unlawful because

there now exists no necessity for the treatment of the mental condition which led to the acquittal by reason of insanity and in fact no such treatment has been administered * * * for approximately six to seven months past. * * *

The hospital explicitly denied these allegations, stating that Rouse

remains antisocial, aloof, and uncooperative, availing himself neither of the service's facilities nor of its people. The petitioner shows no insight into his mental condition and little, if any, improvement obtains.

This petition came on for hearing before Judge Holtzoff on September 13, 1965. Myron G. Ehrlich, Esq., asked the court to hear evidence on Rouse's claim of "failure to accord this accused any treatment at all," which, he urged, "is a violation of his constitutional rights." 1 Tr. 5. Judge Holtzoff declined:

"My jurisdiction is limited to determining whether he has recovered his sanity. I don't think I have a right to consider whether he is getting enough * * * or not enough treatment. * * *" *Ibid.*

Dr. Economon, the Hospital's only witness, testified at length as to Rouse's mental condition, 1 Tr. 6-43, with some reference to the treatment being administered.²² He referred to Rouse's withdrawal from group therapy, to his refusing transfers either within or outside the maximum security building, and to his making "little use of" proffered occupational and recreational therapy, and briefly described environmental therapy, "the basic therapy that is available to * * * Mr. Rouse." 1 Tr. 12, 17-18, 30-31, 36-37.

For appellant, Dr. Albert Marland, a private psychiatrist, testified to having examined Rouse "altogether eight times since March 23rd, 1964," 1 Tr. 44. He agreed with Dr. Econo-

²² As usual in such cases, Judge Holtzoff heard the Hospital's witnesses first, see 1 Tr. 5.

mon's diagnosis, but disagreed with classifying Antisocial Reaction as a mental illness, although he recommended "a conditional release, not an unconditional release." 1 Tr. 46-47. Without supervision, Rouse would repeat his "pattern of getting into difficulty," 1 Tr. 71.

Mr. O'Neill testified concerning his dealings with the Hospital on Rouse's behalf. 1 Tr. 76-80.

Following his testimony, Judge Holtzoff suggested obtaining "the advisory opinion of the Mental Health Commission in this case," 1 Tr. 81, and continued the matter to November 1 for such an opinion after both parties agreed to it. 1 Tr. 82-83.

On November 1, Judge Holtzoff read the Commission's report, which found Rouse "not mentally ill at this time" and opined "that further hospitalization * * * will stifle his future development," although it noted his "arrangements to see a psychiatrist on discharge." That inconsistency "a little bit troubled" him, 1 Tr. 87.

Dr. Clarence E. Bunge of the Commission on Mental Health testified that he did not find Rouse to be suffering from any mental illness at all, or even to fit the diagnosis of Antisocial Reaction, nor did he believe that Rouse would be dangerous if released. 1 Tr. 87-98.

Judge Holtzoff denied relief, noting Dr. Marland's refusal to recommend unconditional release, and summarizing, 1 Tr. 103:

"I think that the petitioner should take advantage, first, of the opportunities of greater freedom in the hospital and, if he shows that he is capable of making use of those opportunities, it may well be that the hospital will admit him to conditional release; but even if it does not, the Court will consider a renewal of the application with a view to possibly granting a conditional release. But I do think that he should first cooperate with the hospital and take advantage of the opportunities which they are willing to accord to him for greater freedom within its walls."

After a temporary mix-up caused by another judge's signing the papers prepared by appellee's counsel for Judge Holtzoff's signature, a final order was entered dismissing the petition on

November 19, 1965, and on November 23 Rouse's counhsel duly noted the appeal which became *Rouse I*.

The lull between storms

During the pendency of the appeal, Dr. Economon again tried to get Rouse to accept a transfer to a less strictly confining ward within John Howard, but Rouse rejected the idea,¹² preferring to remain on Ward 11. After conferring with the ward staff, Dr. Economon eventually ordered Rouse moved to Ward 8, the most privileged ward on that wing of John Howard, on January 3, 1966. Although Rouse displayed some anxiety, this time the transfer "took."

In April, 1966, Rouse was found to be trifling with the emotions of several young girls who were supposed to be his pen pals, expressing his intentions of marrying each of them, misrepresenting himself and, for example, sending one of them a photograph of his handsome cousin as a picture of himself; Rouse described this as "something to kill time with." 2 Tr. 108-110.¹³

Later that month, Rouse's father died, and Dr. Economon spent considerable time both discussing this with Rouse and arranging for him to attend the funeral.¹⁴

Eventually, although he did not think that Rouse had greatly improved, Dr. Economon felt that his adjustment to Ward 8 was sufficient to merit recommending his transfer "off service," out of the John Howard Pavilion to a less restricted facility. Dr. Economon recommended such a transfer on August 5, 1966, and that recommendation was approved by Dr. Cameron on October 4, 1966.¹⁵

¹² Dr. Economon's clinical note of November 2, 1955 (included in appellant's Exhibit 1).

¹³ See also Dr. Economon's clinical note of April 15, 1966 (included in appellant's Exhibit 1).

¹⁴ See the order of the Court of General Sessions allowing Rouse's release from the Hospital for that purpose (included in appellee's Exhibit 1); Dr. Economon's contemporaneous clinical notes (included in appellant's Exhibit 1); 2 Tr. 150-51, 153, 174-75.

¹⁵ The recommendation and approval are included in appellant's Exhibit 1. See also 2 Tr. 68-69.

Six days later, on October 10, 1966, this Court handed down its decision in Rouse's first appeal, reversing and remanding H.C. 287-65 for a new hearing at which the District Court would, *inter alia*, entertain Rouse's claim that he was not receiving treatment. The Court's opinion was subsequently modified by the insertion of a lengthy footnote on October 17, 1966, and again, by an order superseding that footnote, on April 4, 1967.¹⁶

The effect this revival of his litigation had on Rouse is quite clear from the Hospital records. On October 31, 1966 he refused a routine physical examination. On November 30, 1966 he was dropped from occupational therapy for non-attendance and disinterest.¹⁷ On December 2, 1966 he was found drunk on the ward, having smuggled in some liquor.¹⁸ (This last incident was not discussed in the ward's patient government to avoid having the patients recommend he be transferred back to Ward 11; the ward staff ascribed it to the fact that "Mr. Rouse was in the court hearings, and he was quite upset," 2 Tr. 312.)¹⁹

The deposition dispute

Rouse was, indeed, "in the court hearings" again. This Court's mandate was filed below on October 26, 1966, and H.C. No. 287-65 was set down for a new hearing on November 28, later continued to December 12 at the request of appellant's counsel.

On November 20, 1966, appellant served a Notice of Deposition, expressing his intent to depose Dr. Economon and three other members of the staff of the John Howard Pavilion: Dr. David J. Owens, the Clinical Director; Dr. Mauris M. Platkin, the Chief of Service; and Mr. David H. Banks, the chief attendant on Ward 8, appellant's ward. On December 1, appellee

¹⁶ As only the amended footnote 18a appears in the reported opinion, 373 F. 2d 454-55, appellee has appended the original footnote to this brief as Appendix B.

¹⁷ 2 Tr. 118.

¹⁸ 2 Tr. 170-71 (Dr. Economon), 311-13 (Mr. Banks). Mr. Banks ascribes this incident to December 3, 1966.

¹⁹ See also Dr. Bunge's statement that the ward notes indicated appellant "was a model patient" until "around October of this year," i.e., October, 1966. 2 Tr. 305.

filed a motion to quash the Notice of Deposition, raising four grounds of objection: (1) that discovery depositions are not available in a *habeas corpus* proceeding; (2) that taking the depositions would delay the hearing; (3) that requiring the witnesses to testify twice, by deposition and again in court, would be unduly oppressive, since it would further reduce the limited time available to them for the treatment of patients; and (4) that the depositions were unnecessary, in view of appellant's access to both the witnesses and the Hospital records. Appellant replied with affidavits and memoranda rebutting these contentions.

On December 6, the motion to quash came before Judge Holtzoff who expressed doubt that depositions were available in *habeas corpus* proceedings, but based his decision to grant the motion to quash—which he denominated a motion to vacate—solely on his discretion to bar “unduly burdensome” discovery.²⁰ Appellant objected that his access to the prior transcript was insufficient help, because the court had not delved deeply into the treatment issue there, and that the hospital records were of little assistance because

the basic therapy which petitioner is receiving is environmental therapy. * * * The nature of environmental therapy is that it cannot be reflected in any records.²¹

On the very day that Judge Holtzoff's order granting appellee's motion was filed, December 16, 1966, appellant moved in this Court “for clarification of remand order,” contending that taking depositions was so necessary to his ability to prepare his case “in conformity with this Court's mandate” that the Court should clarify its mandate by ordering the District Court to allow such discovery. Appellee opposed this motion as an impermissible interlocutory appeal. On December 29, this Court denied the motion to clarify, finding “that it would not be appropriate to grant the extraordinary relief presently sought.”

The second hearing below

H.C. No. 287-65 thus came on for hearing before Judge Holtzoff again on January 9, 1967. The transcript of that hear-

²⁰ Transcript of December 6, 1966 hearing 17-18.

²¹ *Id.* at 18.

ing is quite full, and is supplemented by two depositions. The relevant portions of the evidence are discussed in the Argument. Appellee thus confines himself here to a skeletonized version of the facts established, some of which have already been stated above.

Dr. Dale C. Cameron, appellee, was the first witness. His testimony primarily concerned the adequacy of the treatment afforded to appellant in terms of the adequacy of staff and facilities. The principal exhibit introduced on this point, appellee's Exhibit 3, a table comparing the staffing ratios of the John Howard Pavilion with the ratios recommended by the American Psychiatric Association,^{21a} is appended to this brief as Appendix A. This exhibit was supplemented by proof that Saint Elizabeths Hospital is accredited, as are only 32% of the state and local mental hospitals in the United States, and by testimony that, considering the APA standards unworkable and somewhat obsolete, the Hospital had undertaken a staffing study of its own and arrived at a far higher estimate of its needs than that reflected in the standards. This process was continuing with the development of plans to change the John Howard Pavilion into a unit in which patients would remain under the care of the same "treatment team" from initial admission through release, rather than being shifted from one team to another on leaving maximum security. Dr. Cameron also stated what he termed "the rubrics of treatment," the "components" of a treatment program and how each should be assessed to determine whether a patient is receiving adequate treatment. 2 Tr. 33-38, 40-43. He expressed an opinion that the treatment given to appellant "was adequate, even though not ideal." 2 Tr. 43. He was cross-examined at some length, 2 Tr. 45-76.

The second witness called was Dr. Economon, who again expressed the opinion that appellant was still suffering from a mental illness, Antisocial Reaction, and that he would be dangerous to himself or to others if released into the community. He had but briefly outlined the nature of the treatment being administered to appellant under his direction when the court broke off the hearing to resume a jury trial.

^{21a} STANDARDS FOR HOSPITALS AND CLINICS 60-61 (1956 ed., revised 1958) (hereinafter STANDARDS).

During Dr. Economon's testimony, the court obtained the agreement of counsel that the transcript of the prior hearing, here cited as 1 Tr., could again be considered, and subsequent testimony was substantially limited to the events since that hearing. 2 Tr. 108-110. At the close of the day's proceedings, appellant's counsel informed the court of problems created by the fact that he had two out-of-town expert witnesses, one from Denver, Colorado, who could not wait indefinitely to testify. Judge Holtzoff suggested, and appellant's counsel requested, that the witness' testimony be taken by deposition. 2 Tr. 121. Appellee's counsel repeated his objection that depositions "are not available under the habeas corpus statutes," but he was overruled, although Judge Holtzoff took pains to remind appellant's counsel that "testimony in open court" would be "more impressive." 2 Tr. 121-22. He also granted appellant's request to increase the number of his expert witnesses on treatment (set at two in a pretrial conference "to avoid burdening the court's time") in the light of this deposition procedure, by allowing "the deposition of an additional expert." 2 Tr. 123.

The hearing resumed on January 12. At the outset of the second day's proceedings, Judge Holtzoff ordered a change in the order of proof, interrupting the examination of Dr. Economon by appellee's counsel and directing appellant's counsel to go forward with his evidence. Appellant then recalled Dr. Economon to the stand. 2 Tr. 130-33.

Dr. Economon's testimony on the second day was primarily a more detailed exposition of the environmental, or milieu, therapy being applied to appellant on Ward 8 of the John Howard Pavilion, and of appellant's responses to that and to the various efforts to engage him in other modes of treatment. He summarized this in a lengthy statement at 2 Tr. 155-163.

Appellant then obtained further corroborating detail by calling Odis McGee, an attendant on his ward. Mr. McGee described the functioning of the ward in general terms, but his most remarkable testimony concerned the fact that he had conducted a group for patients who wanted "to come to discuss a few problems on the ward," which Rouse had declined to attend. 2 Tr. 189-98, especially 192, 196.

The second day concluded with the beginning of the testimony of Dr. Alan M. Kraft, Director of the Fort Logan Mental Health Center in Denver, Colorado, and an Assistant Professor of Psychiatry at the University of Colorado Medical School. Dr. Kraft, drawing on nine years of directing "the clinical operation of milieu therapy programs," 2 Tr. 201, was called as an expert in that particular field of psychiatry. His testimony was not finished in open court, and had to be concluded by deposition. He concluded that "the milieu therapy to which Rouse was exposed * * * only minimally comports with" generally accepted standards in the profession for that mode of treatment. K. Dept. 19. Asked whether appellant had "been afforded adequate milieu therapy," he replied, "I don't know." K. Dept. 19.

Appellant also took the testimony of Dr. Israel Zwerling, Director of the Bronx State Hospital in New York City and a Professor of Psychiatry at the Albert Einstein College of Medicine, by deposition on September 13. Dr. Zwerling expressed an opinion that the milieu therapy afforded to appellant "is very substantially inadequate." Z. Dep. 13. Like the other testimony on this question, his deposition is more fully discussed below.

The depositions of Drs. Kraft and Zwerling were presented to the court at the beginning of the third day of hearing, January 16. Appellant then substantially completed his case by calling three more witnesses.

Dr. David J. Owens, the Clinical Director of the John Howard Pavilion, testified generally to the operation of his service. He also estimated that only four to six of the 350-odd patients in John Howard were receiving individual psychotherapy, 2 Tr. 257, and that 25 to 50 were receiving group therapy. 2 Tr. 259. He placed 50 of his 350 charges in the "diagnostic phase, rather than the treatment phase" of their hospitalization. 2 Tr. 269-70.

Dr. John F. Borriello, the psychologist who had been the leader of the psychotherapy group in which appellant had been enrolled two years earlier, described the operation of that group, as well as how appellant had been selected for it and how and why appellant had withdrawn from it.

Dr. Clarence E. Bunge, who had testified at the prior hearing, reiterated his prior opinion that appellant was no longer mentally ill, that further hospitalization would stifle his development, and that he should be released. He thought appellant had improved since his examination in October, 1965, and was now more lucid in his thinking and concrete in his plans.

Appellant rested his case with Dr. Bunge. Appellee then called one final witness, Mr. David H. Banks, the supervising nursing assistant of appellant's ward. He described the operation of his ward, both in general terms and with specific reference to specific incidents in which appellant had been involved. He also stated, in response to the last question asked in the case, that he had spent approximately twenty hours in court in connection with the hearing. 2 Tr. 333.

The court refused to allow appellee's counsel to recall Dr. Economon for further questioning, and also declined his suggestion that Rouse, who had not testified at either hearing, should be called as a witness. 2 Tr. 334-35.

After argument by counsel, the court made oral findings of fact and conclusions of law, finding that appellant had failed to establish his eligibility for release under 24 D.C. Code § 301(e) on grounds of recovery, and that he "has been receiving and is now receiving treatment which is adequate according to proper standards." 2 Tr. 416. Thus the petition was again dismissed, and the appeal in No. 20,881 followed.

H.C. 179-67: the third hearing

On April 11, 1967, appellant's counsel filed a new petition for *habeas corpus*, H.C. No. 179-67, which alleged that the circumstances of his original trial in the Municipal Court were such that his commitment under 24 D.C. Code § 301(d) was invalid. His petition alleged that "he did not voluntarily and knowingly introduce the insanity defense in his trial or authorize his attorney to do so," urging that the *Lynch*²² and *Mullen*²³ decisions thus made § 24-301(d) inapplicable to him. He also urged that automatic commitment under § 24-301(d) should be held unconstitutional. Copies of the original court

²² *Lynch v. Overholser*, 369 U.S. 705 (1962).

²³ *Cameron v. Mullen*, No. 20,308, D.C. Cir., decided March 2, 1967.

papers and of the trial transcript, cited herein as T. Tr., were attached to his petition.

The Hospital replied that petitioner had raised the defense of insanity through his retained counsel, thus subjecting himself to automatic commitment under the statute; that the statute was constitutional; that appellant should be held barred by *laches* from asserting any facts outside the record of his trial; and that his failure to pursue appropriate remedies, particularly direct appeal, in the trial court should bar relief in *habeas corpus*.

A hearing was held on the new petition before Judge McGarraghy on April 24, 1967. Appellant, the sole witness, asserted his ignorance of his rights in 1962 and generally expanded on the trial record. Appellee's counsel expanded his argument that appellant had failed to exhaust available remedies, urging that he should be required to proceed in the trial court by a motion to vacate the judgment, or for a new trial, rather than being allowed to jump into *habeas corpus*. Judge McGarraghy, unimpressed by that contention, ruled on the merits and dismissed the position.

On May 2, 1967, Judge McGarraghy signed the findings, conclusions, and order submitted by appellee. That document contained the following findings of fact:

3. The circumstances in which the defense of insanity was asserted in petitioner's trial are shown by the transcript of that trial which petitioner has filed here as an exhibit. That transcript shows that the defense was joined in by petitioner's counsel, who actively sought an acquittal of his client on grounds of insanity.

4. The transcript also shows that petitioner acquiesced in the assertion of the insanity defense, a conclusion which is bolstered by the fact that petitioner did not complain of the result of asserting that defense, mandatory commitment, under § 24-301(d), in any way until January 7, 1964, when he executed his first petition for habeas corpus, nor challenge that commitment on the grounds presently asserted until the filing of the instant petition, his fourth. The Court finds that peti-

tioner both sought and accepted the consequences of the acquittal by reason of insanity.

Judge McGarraghy also granted appellant leave to appeal from his denial of *habeas*, thus bringing Rouse's third appeal, No. 20,962, to this Court.²⁴

Appellant requested consolidation of his second and third appeals, which was granted by order entered May 11, 1967. Then, on May 17, 1967, this Court *sua sponte* ordered the appeals thus consolidated to be heard *en banc*.

SUMMARY OF ARGUMENT

In *Rouse I*, this Court went beyond all prior precedent in holding that mental patients can petition for *habeas corpus* on the ground of lack of psychiatric treatment. The hearing held below, on remand from *Rouse I*, allows the Court to reassess its abstract pronouncement in the practical context of the first record of litigating an alleged denial of treatment.

In appellee's view, this permits the Court to undo a pernicious precedent before it can do further damage. The extensiveness and detail of the record, which appellant significantly assails as insufficient, amply demonstrate the folly of further self-defeating litigation of the adequacy of psychiatric treatment—self-defeating both in its anti-therapeutic effect on the particular patient, and in its manifestly inequitable effect of taking treatment personnel away from all their other patients to tell a court how they are treating the litigator, and why. The wisdom of strictly limiting such litigation has here been amply documented on the very first round, and gives further weight to appellee's suggestions elsewhere that assertions of deficient treatment by civil patients should be handled administratively, and not judicially, in the first instance.

²⁴ Some subsequent developments, not established of record, may be of interest to the Court. On January 19, 1967, appellant was transferred off service from the John Howard Pavilion to the Cruvant Division of Saint Elizabeths Hospital, a less secure facility. On April 25, 1967, he "eloped," to use the Hospital's somewhat fanciful phrase, but was thereafter arrested on a bench warrant issued by the Court of General Sessions and returned to the Hospital. He was again on Ward 8 of John Howard from April 29 to June 20, 1967, when he was re-transferred to Cruvant.

Appellee does not argue below that patients committed in criminal cases have no right to treatment, only that their rights are defined solely by the due process clause of the Fifth Amendment, which forbids confining the mentally ill in therapeutic facilities which are prisons in all but name, or denying them treatment for manifestly arbitrary and discriminatory reasons. A *bona fide* effort to treat, and not merely to incarcerate, is all that must be shown to justify further confinement. If the "adequacy" of that effort is to be assessed, that should only be done in the context of the patient's degree of recovery, by counterbalancing his allegedly unsatisfied need for treatment with the public interest in his further detention. If it is not arbitrary and discriminatory to continue the patient's detention, he is not entitled to his release.

The record here clearly shows that appellant's treatment met that standard. Indeed, his treatment was even shown to have met the higher standard of *Rouse I*. All objective criteria indicated that adequate staff were administering appropriate treatment, and appellant's proof that the treatment was inadequately applied was not only subjective, but also inconsistent and insufficient.

There was no serious question below that appellant was entitled to his release because he had recovered, and appellee does not discuss that matter at any length. Appellant also challenges the management of the hearing below on his treatment, but his complaints fail to show prejudice compelling reversal for a new hearing, particularly since he only seeks further inquiry into matters already litigated at excessive length.

Appellant's second appeal challenges the validity of his commitment. Appellee submits that the factual inquiry launched by appellant below was inappropriate to *habeas corpus*, and should have been requested in the trial court on a motion to vacate its judgment or a motion for a new trial. Trial judges should not be subjected to second-guessing by other courts without giving them an opportunity to correct themselves.

On the merits, appellant's contentions were rightly rejected below. His brief here shows no cause for reconsidering the constitutionality of 24 D.C. Code § 301(d), the statute under

which he was committed, whose validity has long been settled. The record of his trial shows beyond question that the defense of insanity was interposed by appellant's able and experienced counsel, so that appellant was properly subject to the mandatory commitment provision he now attacks. The District Court properly rejected appellant's contention that he disavowed his counsel's actions, and correctly found that appellant was belatedly disclaiming what he had previously sought.

ARGUMENT

I. Appellant is not entitled to release on the ground of abrogation of his "right to treatment"

Appellant argues that the record shows that he has not received adequate treatment and should therefore be released. That argument is based upon several faulty premises: that a litigable right to treatment was created for him in 1964 by the Ervin Act, 21 D.C. Code § 562; that he is entitled to his release upon a showing that his treatment does not meet the latest standards for psychiatric care; and that his treatment has been shown to be inadequate under the applicable standards. None of these contentions withstands close examination. The "right to treatment" which appellant seeks to invoke here is one whose vindication by a court is nearly impossible. *Rouse I*, which found that right in the 1964 civil commitment statute, should be rejected both because it misreads the statute and because it would lead both courts and hospitals through an endless quagmire of litigation in pursuit of a medical will-o'-the-wisp. The extended hearing below not only failed to show deficiencies in appellant's treatment, but demonstrated that further litigation in this area would place undue burdens on both courts and hospitals. *Rouse I* has proven its unworkability and should be reconsidered and rejected by the Court *en banc*.

A. *Rouse I* has no support in prior court decisions

Rouse I was a completely new departure in the law. No other jurisdiction's courts had discovered a right to treatment

enforcible by a mental patient against his doctor. Two states had squarely faced the matter, New York and Massachusetts. In New York, the Appellate Division held that the courts could not consider the adequacy of a patient's treatment in a *habeas corpus* proceeding:

It is the policy of the State to care for and protect mentally ill persons and, if possible, to cure them of disease. * * * But this policy does not confer on the mentally ill a right to release in the event of claimed inadequate treatment.

People ex rel. Anonymous v. LaBurt, 14 App. Div. 2d 560, 218 N.Y.S. 2d 738, 739 (2d Dept. 1961), *cert. denied*, 369 U.S. 428 (1962). The Supreme Judicial Court of Massachusetts had, reasoning from this Court's decision in *Miller v. Overholser*, 92 U.S. App. D.C. 110, 206 F. 2d 415 (1953), held that commitment to a penal institution was invalid under the state's sexual psychopath statute. *Commonwealth v. Page*, 339 Mass. 313, 159 N.E. 2d 82 (1959), reasons that to support a confinement for a remedial purpose, the remedial aspect of confinement must have some foundation in fact—manifestly absent in a prison. Thereafter, in *Commonwealth v. Hogan*, 341 Mass. 372, 170 N.E. 2d 327 (1960), the court found that, although the treatment facility where the inmate was confined 'left much to be desired,' its remedial function had a foundation in fact; this was enough to sustain continued confinement.²⁸ The court explicitly rejected "any attempt to state the standards to be observed in a treatment center." *Id.* at 375-76, 170 N.E. 2d 331.

Thus no other court's decisions support *Rouse I*. This Court's decision in *Easter v. District of Columbia*, 124 U.S. App. D.C. 33, 361 F. 2d 50 (1966), does not suggest that adequacy of treatment is relevant to the validity of confinement, only that criminal sanctions cannot be applied to an alcoholic for what Congress has deemed a non-volitional act requiring treatment

²⁸ The facts found determinative were the segregation of sexual psychopaths from the criminally insane at the State hospital, the availability of the hospital's medical staff, a diagnostic staff of two physicians, and two psychiatric social workers.

rather than punishment. Neither *Robinson v. California*, 370 U.S. 660 (1962), nor *Driver v. Hinnant*, 356 F. 2d 761 (4th Cir. 1966), goes beyond *Easter* in this respect. Both hold only that disease conditions require treatment, rather than punishment; neither establishes what constitutes "treatment." Both strongly suggest, as does *Commonwealth v. Hogan*, *supra*, that confinement for treatment need only be minimally distinguishable from imprisonment to be constitutionally valid. This doctrine is further discussed *infra*, pp. 34-40, in appellee's discussion of the appropriate legal standard for assessing psychiatric care. Suffice it for now that *Rouse I*, in going beyond such a standard, had no decisional support. The Court was forced to search for a distinction between commitment under 24 D.C. Code § 301(d) and the commitments reviewed in New York and Massachusetts. It found none.

B. Commitment under 24 D.C. Code § 301(d) entails no statutory right to treatment

The prop used by the majority in *Rouse I* is 21 D.C. Code § 562 (Supp. V. 1966),²⁶ which upon close inspection proves to be a rather weak reed. The legislative history of that statute reveals that it was never intended to apply to persons mandatorily committed to a mental hospital pursuant to 24 D.C. Code § 301(d). It originated as a part of the District of Columbia Hospitalization of the Mentally Ill Act, P.L. 88-597, § 9(b), 78 Stat. 951 (1964), and with minor amendments was re-enacted into positive law, along with the rest of Titles 18-21 of the D.C. Code, in P.L. 89-183, 79 Stat. 685, 758 (1965). Notwithstanding *Rouse I*'s construction of the statutory language,²⁷ the provisions of the 1964 Act were clearly designed to apply only to persons committed either of their own volition or by involuntary civil commitment.

Speaking of the bill which later became the 1964 Act, the House report defined its intended scope:

²⁶ 373 F. 2d 452-53. It should be noted that the applicability of this statute was neither briefed nor argued by the parties.

²⁷ *Id.* at 453-54.

This bill applies only to mentally ill persons in the District of Columbia committed by voluntary act or through civil commitment proceedings, and does not apply to persons committed to a private or public hospital in the District by order of the court in a criminal proceeding. H.R. Rep. No. 1833, 88th Cong., 2d Sess. 3 (1964).

To clarify any ambiguities as to the coverage of the bill, the House of Representatives amended the bill's definition of "mentally ill person." As reported out of the Senate Judiciary Committee and passed by the Senate, the bill defined "mentally ill person" as "any person who has a mental illness." S. Rep. No. 925, 88th Cong., 2d Sess. 13 (1964); 110 Cong. Rec. 14549-14563 (1964). The House District of Columbia Committee added an additional phrase providing that that term would "not include a person committed to a private or public hospital in the District of Columbia by order of the court in a criminal proceeding." H.R. Rep. No. 1833, *supra* at 1, and in this form it passed the House. 110 Cong. Rec. 20792 (1964). Senator Ervin, the bill's sponsor and principal spokesman, told the Senate in explaining the House amendment:

[This amendment would] reaffirm the intent of the authors that the bill applies only to civil hospitalization procedures. 110 Cong. Rec. 21345 (1964).

The Senate concurred in the House amendment.²⁸ 110 Cong. Rec. 21346 (1964). See also H.R. Rep. No. 1833, *supra* at 7.

In addition to the legislative history which the *Rouse* majority expressly rejected as controlling,²⁹ the plain language of the statute itself precludes application of 21 D.C. Code § 562 to anyone committed to a mental hospital under 24 D.C. Code

²⁸ The definition now reads:

"[M]entally ill person" means a person who has a mental illness, but does not include a person committed to a private or public hospital in the District of Columbia by order of the court in a criminal proceeding. . . . 21 D.C. Code § 501 (Supp. V. 1966).

²⁹ See footnote 18a of the majority opinion in *Rouse I*, added by order dated October 17, 1966, superseded by order of April 4, 1967, Appendix B hereto; *Rouse I*, 373 F. 2d 454-55, n. 18a.

§ 301(d). The 1964 Act, in both its original³⁰ and revised³¹ form, contains a section defining the application of what is now § 562 to patients involuntarily committed "in a noncriminal proceeding" prior to the date of enactment. As now in effect, that section reads as follows:

Subject to subsection (b) of this section, the provisions of sections 21-546 to 21-551, *subchapter V of this chapter* and sections 21-585 and 21-588 apply to a person who, on or after January 1, 1966, is a patient in a hospital in the District of Columbia by reason of having been declared insane or of unsound mind pursuant to a court order entered in a noncriminal proceeding prior to September 15, 1964. 21 D.C. Code § 589(a) (Supp. V, 1966) (emphasis added).

Subsection (b) establishes time limitations for requests for examination under section 546, the primary remedy established by Congress for civilly committed patients seeking either release or treatment;³² Section 562, the linchpin of the *Rouse I* opinion, is included in subchapter V.³³ Section 589 thus sets limitations on the assertion of rights under the Act by civil patients, for whom those rights are expressly intended. It is necessary to stand logic on its head to conclude that Congress intended the same rights to apply to other types of patients, not mentioned, whose access to those rights would not be limited by Section 589. This feat is only accomplished in the present footnote 18a of *Rouse I*, 373 F. 2d 454-455, by ignoring subsection (b) and reading subsection (a) as though it set the outer limits on the application of, *inter alia*, Section 562. Section 589(a) extends the patients' rights created by the 1964 Act to those committed under prior hospitalization statutes, while § 589(b) places on such patients roughly the same time requirements for asserting those rights as § 21-546 places on those committed

³⁰ P.L. 88-597, § 17, 78 Stat. 963 (1964).

³¹ P.L. 89-183, 79 Stat. 753 (1965).

³² See appellee's briefs in *Dodson v. Cameron*, No. 20,573, *Stults v. Cameron*, No. 20,576, and *Brody v. Cameron*, No. 20,569, now pending in this Court.

³³ Subchapter V corresponds to § 9 of the original Act.

under the 1964 Act.³⁴ There is no "ambiguity" to that, and, considered together with the rest of the 1964 Act and the unambiguous legislative history, Section 589 compels the conclusion that Section 562, like the rest of the 1964 Act, was intended to apply only to patients hospitalized under the Act or its predecessors.

Rouse I reasons that since other sections of the 1964 Act apply only to patients hospitalized thereunder, or to "mentally ill persons" as defined by § 21-501, and since § 562 contains no such limitations, § 562 "was intended to cover persons hospitalized under any statutory authority."³⁵ But this flies in the face of the clear statements by Senator Ervin, sponsor of the 1964 Act, that "It has no application to hospitalization arising out of criminal proceedings," and that "Subcommittee concentration on the civil aspects" had delayed action "on S. 1109, a bill dealing with the rights of the mentally ill in criminal cases," quoted in Judge Danaher's cogent dissent in *Rouse I*, fn. 14, 373 F. 2d 466, 467. The *Rouse I* majority has in effect mousetrapped Congress by holding that, in legislating as to civil patients, it was perforce covering those committed in criminal cases as well. This position has some semantic and theoretical basis, but no reasoned foundation in the legislative

³⁴ § 21-589 was originally enacted in 1964 as § 21-366:

The provisions of [the relevant equivalents of provisions specified in § 21-589(a)] shall be applicable to any person who, on or after September 15, 1964, is a patient in a hospital in the District of Columbia by reason of having been declared insane or of unsound mind pursuant to a court order entered in a noncriminal proceeding prior to such date of enactment; except that any request for an examination authorized under section 21-357 [the equivalent of §§ 21-546 through 549; i.e., under § 21-546] may be made by such person, or his attorney, legal guardian, spouse, parent, or other nearest relative, after the expiration of the thirty-day period following September 15, 1964 and not more frequently than every six months thereafter.

If there is any significance to such changes from the 1964 to the 1965 version of the Ervin Act—and the majority in *Rouse I* has admonished us not to "assume" that "amendments" to the Act were "purposeless," footnote 18a, adopted October 17, 1966, Appendix B hereto—the new version, § 589, indicates an intention on the part of Congress to clarify its desire that patients' rights under the Act be asserted through § 546, which is only available to civilly committed patients.

³⁵ 373 F. 2d 454.

history. Having already stated its position, the *Rouse I* majority sought to cover this lack by post-judgment addition of the first footnote 18a, Appendix B hereto, and then by superseding that with a new footnote, 373 F. 2d 454-55, almost six months later. The reasoning of that new footnote is illustrated by its concluding that for §21-589(a) to "apply to those civilly committed before September 15, 1964, but not to those criminally committed at the same time"—the application evidently intended—"is especially irrational in the context of a statute *which we have construed* to provide a right to treatment without distinction between those civilly committed and those criminally committed after September 15, 1964." (Emphasis added.) With all due respect to this Court, that is bootstrap logic. Contrary data on the very point at issue are not answered by saying that the point has been decided without considering them.

Reading § 562 as applicable only to civil patients does not, as *Rouse I* suggests, impute to Congress "an intent to discriminate irrationally among patients in mental institutions," 373 F. 2d 455, n. 18a. *Baxstrom v. Herold*, 383 U.S. 107 (1966), cited as barring such an imputation, holds only that a state may not set up classifications among its "civilly committed" mental patients which lack "all semblance of rationality," *id.* at 115, and explicitly states that

Classification of mentally ill persons as either insane or dangerously insane of course may be a reasonable distinction for purposes of determining the type of custodial or medical care to be given. * * * *Id.* at 111.

Indeed, *Baxstrom's* very complaint was that he was a civil patient at best, and could not arbitrarily be housed with the "criminally insane." His case surely stands for the proposition that there can be distinctions between civil and criminal commitments. See also *Miller v. Overholser*, 92 U.S. App. D.C. 110, 206 F. 2d 415 (1953).

In short, appellant's reliance on *Rouse I's* reliance on § 562 appears ill founded. This would seem to render immaterial here the question of whether § 562 requires "suitable and ade-

quate treatment" regardless of "lack of staff or facilities," *Rouse I*, 373 F. 2d at 457. Should the statute be held to apply, however, appellee submits that *Rouse I* misconstrues the standard it establishes.

Section 562 is based upon Section 19 of *A Draft Act Governing Hospitalization of the Mentally Ill*, Public Health Service Pub. No. 51 (1952) (italicized language omitted in § 562):

Every patient shall be entitled to humane care and treatment, and, *to the extent that facilities, equipment, and personnel are available*, to medical care and treatment in accordance with the highest standards accepted for medical practice.

The relevant sentence of § 562 is:

A person hospitalized in a public hospital for a mental illness shall, during his hospitalization, be entitled to medical and psychiatric care and treatment.

Accounting for differences of phraseology, this is really nothing more than a shorter version of the Draft Act, eliminating the two italicized phrases which so qualify each other that they cancel each other out. *Rouse I* reads the second phrase back into the statute without the counterbalance of the first; we submit that this was incorrect, and that treatment must be judged not merely "in the light of present knowledge,"²⁴ but also in the light of the means available.

It would of course be inconsistent with the statutory scheme embodied in 24 D.C. Code § 301 as a whole, and it might present constitutional problems, if a person such as appellant were confined to a penal institution or subjected to regulations generally associated with such institutions. See *Rouse I*, 373 F. 2d 460-61; *Ragsdale v. Overholser*, *supra* at 315, 281 F. 2d at 950 (concurring opinion); *District of Columbia v. Walters*, D.C. Ct. Gen. Sess. No. D.C. 18150-66, decided August 16, 1966; *Commonwealth v. Page*, 339 Mass. 313, 159 N.E. 2d 82 (1959); cf. *Easter v. District of Columbia*, 124 U.S. App. D.C. 33, 361 F. 2d 50 (1966). A sign reading "mental hospital" over the door of a prison building—see *Benton v. Reid*, 98 U.S. App. D.C. 27, 231 F. 2d 780 (1956)—would not alone justify confining mental

²⁴ 373 F. 2d 456.

patients there. It is reasonable to assume that Congress contemplated that persons committed to a mental hospital pursuant to 24 D.C. Code § 301(d) would be treated. But there is no reason to believe that Congress intended the courts to review *in vacuo* the nature or suitability of whatever treatment they receive.

Apart from the extreme difficulty the courts may have in resolving complex medical questions as to the appropriateness of a particular course of treatment or even the need for such treatment—a difficulty implicitly acknowledged in *Rouse I*²⁷ and profusely documented both by the record on remand and by Rouse's counsel's arguments that that record is insufficient—there are three other factors which militate against reaffirmation of *Rouse I* by the Court *en banc*.

First, the type of treatment afforded to a patient is dictated in part by non-psychiatric considerations, especially in a tax-supported hospital like Saint Elizabeths. Such hospitals depend on appropriations from the public treasury to meet operating and maintenance costs. The size of the staff, the number of beds, the condition of equipment, the modernization of facilities and other similar matters are controlled by the legislative determination as to how much money will be appropriated for each fiscal year. With numerous requests for public funds coming from all parts of the government, Congress must exercise its informed judgment in parceling out the money. Although *Rouse I* states that "continuing failure to provide suitable and adequate treatment cannot be justified by lack of staff or facilities,"²⁸ surely Congress could not have intended patients to be treated by a larger staff and through the use of better facilities than that body itself has provided through its appropriations. The judiciary, of course, is without power to compel Congress to appropriate funds for any specified purpose, however worthy it may be of legislative consideration. *Hart v. United States*, 118 U.S. 62 (1886); *Knote v. United States*, 95 U.S. 149 (1877); see *Reeside v. Walker*, 52 U.S. (11 How.) 272 (1851) (mandamus will not lie against the Secretary of

²⁷ 373 F. 2d 457.

²⁸ *Id.*

the Treasury to pay a claim when Congress has not appropriated money to pay it). These considerations led Judge Greene in *District of Columbia v. Walters*,³⁹ *supra*, to say (memorandum opinion at 13-14):

Where the expenditure of funds is involved, the courts can and should operate only in the framework created by legislative and executive branches. In essence, the choice between various alternatives must therefore be for the District of Columbia, not the Court. The chronic alcoholic problem is but one of the many facing this city. Varied demands, some of them no doubt as justified as those arising out of the chronic alcoholic situation, are constantly being made upon the necessarily limited funds and energies available to the District government. It is that government which has the responsibility for making a choice among the multitude of needs; it is not the function of this Court so to shape its orders as to bring pressure to bear to cause the District to prefer one of its responsibilities over another.

Second, there are economics of human resources that must be weighed. A hospital with funds to hire adequate personnel may be unable to find them, and its ability to attract personnel in the seller's market of the psychiatric manpower shortage may fluctuate widely and perhaps irrationally. Is Saint Elizabeths to release or readmit patients every year according to its ability to fill staff vacancies, which is evidently a matter of chance? "Will the community be better served by allocating its available psychiatrists, psychologists, and therapists to the care of people who are committed to mental hospitals, rather than to the prevention of such commitments by work in

³⁹ The *Walters* case arose in the still turbulent wake of this Court's decision in *Easter v. District of Columbia*, *supra*. In *Walters* the court was faced with the problem of what should be done with chronic alcoholics when there was no institution suitable for their rehabilitation to which they could be sent.

⁴⁰ St. Elizabeths . . . signed up no interns for its 10 positions [for the year 1967-1968]. Dr. Dale C. Cameron, the superintendent, expressed surprise, especially since "we had more interns this year than ever before. We don't know what happened," he said.

The Washington Post, Sunday, March 19, 1967, p. C5, Col. 8.

community mental health clinics? " What of the allocation of staff and resources within the Hospital? The courts are simply not equipped to arbitrate between the conflicting demands of a hospital limited in size and staff, but *Rouse I* would require them to do so. Such "difficult decisions . . . as to relative needs and priorities" are best made by the Superintendent and his subordinates, *Mitchell v. McNamara*, 122 U.S. App. D.C. 224, 225, 352 F. 2d 700, 701 (1965). They are charged by Congress both with caring for the mentally ill and with broad discretion in deciding how the mentally ill are to be cared for, and, as psychiatrists, they are qualified to discharge those duties. The balance which they strike may be thrown badly awry by courts ordering additional treatment for certain patients which cannot be given without taking it away from others, and awarding treatment to the most litigious patients at the expense of their silent brethren. This has little relationship to the proper functioning of hospitals, nor should hospital administrators and personnel be taken from their central task of treating the mentally ill to answer protracted inquiries into that treatment.

Third, the inquiry is self-defeating. This case indicates that anything more than a yes-no, black-white investigation of the treatment of one patient may well be anti-therapeutic for him,⁴² and obviously must take the personnel responsible for treatment away from their duties, to the detriment of the other patients in their care. At the remand hearing, the following Hospital personnel spent about twenty hours apiece in court: " Mr. Banks, the senior nursing assistant on Rouse's ward; Dr. Economon, ward administrator for that and two other wards; and Dr. Borriello, a clinical psychologist who conducts group and individual therapy and administers psychological tests for various patients throughout the Hospital. Several others spent parts of a day or days there: Dr. Cameron, the superintendent; Dr. Owens, the clinical director of the maximum security divi-

⁴² Compare the attitude toward crime prevention in President's Commission on Law Enf. and Adm. of Justice, *THE CHALLENGE OF CRIME IN A FREE SOCIETY* (1967).

⁴³ See testimony of Dr. Economon, 2 Tr. 182-183; Zwerling Dep. 28, 82.

⁴⁴ This was Mr. Banks' estimate in answer to the last question of the hearing, 2 Tr. 333.

sion; and Odis McGee, a ward attendant. (Dr. Mauris M. Platkin, the chief of service at John Howard, was subpoenaed but excused before he was called as a witness.) Rouse also had the heads of two other mental hospitals in court for two days waiting to testify as experts on treatment, and a member of the Mental Health Commission on tap for all four days of the hearing. Rouse did not benefit from the gathering of all this talent, and their gathering at his behest can only be described as a shocking waste of psychiatric manpower, already in short supply, at the expense of dozens, if not hundreds, of other mental patients. Since any inquiry into present treatment must intrinsically decrease the available supply of treatment man-hours, the inquiry should be summary, or administrative,⁴⁴ if it is to be made at all.

Lack of treatment, if it be judicially cognizable, should be litigable only in the usual context where the patient seeks his release on the ground he recovered to such an extent that further hospitalization is unnecessary. Treatment is, at most, another factor for the *habeas* court to consider in deciding whether the Hospital superintendent is arbitrary or capricious in failing to certify a patient for release under § 24-301(e), or for the criminal court to consider when a certification is contested. In either capacity, the court always weighs the patient's right to liberty against the community's need for protection from him, and against his need for protection from himself.

C. The Constitution requires only that sufficient treatment be afforded to make therapeutic confinement distinguishable from imprisonment

There can manifestly be no absolute right to be released if no treatment is possible. The extreme paranoid schizophrenic who is beyond the reach of therapy⁴⁵ is not therefore eligible for release; his danger quotient is too high. Similarly, a patient suffering from a Chronic Brain Syndrome caused by senility may be unable to profit from more than mere custodial care,

⁴⁴ Cf. *Rouse I*, 373 F. 2d at 456, n. 22. This point is expanded in appellee's briefs in *Dobson v. Cameron* and *Brody v. Cameron*, *supra*, in regard to the exercise by civilly committed patients of their rights under the 1964 Act.

⁴⁵ E.g., *Borzellino v. Cameron*, H.C. No. 242-67, D.D.C. (threats to the President; highly delusional); See Crim. No. 1138-64, D.D.C.

but our common humanity does not release her to walk the streets in a confused state, unable to protect herself.⁴⁵ Not even *Rouse I* could convince a District judge to release a sexual psychopath committed to Saint Elizabeths for over ten years, who had all but exhausted the Hospital's willingness to attempt further therapy but who, each time he had escaped, again sexually molested small children.⁴⁶ Nor does reason allow a patient to obtain his release by refusing, obstructing, or evading treatment.⁴⁷

As this Court stated only five years ago:

Inherent in the statutory scheme, whether we like it or not, is the proposition that one who is "incurably insane" and "incurably dangerous"—if there are such—may be hospitalized indefinitely. For such cases nothing less was intended by Congress and nothing less will protect the patient and society from the hazards involved. *Overholser v. O'Bierne*, 112 U.S. App. D.C. 267, 269, 302 F. 2d 852, 854 (1962).

But that is not to say that there is not, in some cases, a point where the return from continued hospitalization is so diminished by a lack of treatment potentiality, combined with a degree of improvement which renders the patient a minimal danger, that the consideration of inability to treat swings the balance in favor of release.⁴⁸

Of course there is such a point, and *habeas* judges have been considering whether it has been passed for years. Judge Holtzoff

⁴⁵ See *Lake v. Cameron*, 124 U.S. App. D.C. 264, 364 F. 2d 657 (1966).

⁴⁶ *Hemphill v. Cameron*, H.C. No. 66-67, D.D.C. (continued for six months for new treatment efforts by order of May 25, 1967, McGarraghy, J.). See Crim. No. US 3304-57, Mun. Ct. D.C. (sexual psychopath commitment). Crim. No. 1056-60, D.D.C. (not guilty, insanity on charges of indecent acts with minors).

⁴⁷ See APA Statement, Appendix C hereto, at p. 77 *infra*.

⁴⁸ This theory appears to have been raised, in a somewhat warped form, in *Collins v. Cameron*, No. 20,371, D.C. Cir., decided April 21, 1967 (Burger, J., with Prettyman, J.; McGowan, J., concurring in result). There, however, the patient argued that confinement solely for drug therapy, "administered as well outside the hospital as within," was unlawful, but he was clearly both severely psychotic and receiving other forms of treatment, slip op. at 3-4.

evidently did so below; see his opinion at the first hearing, 373 F. 2d 467-68 (Appendix to opinion of Judge Danaher). It may be well, however, for this Court to outline just how and when the treatment factor should enter into the release equation, and to give yet another *en banc* quietus to dissenting theories⁴⁰ of a mechanical cut-off at the maximum sentence date⁴¹ which have won adherence from some trial judges.⁴²

The basic standard for release of a patient such as Rouse is found in 24 D.C. Code § 301(e) as construed by this Court in a series of cases going back to *Overholser v. Leach*, *supra*, in 1958.⁴³ Normally, if a patient has not recovered to the extent specified in the statute and the cases, he cannot be released regardless of whether he is receiving treatment which is "adequate" as that term is defined by *Rouse I*. In the passage quoted above from *O'Beirne*, this Court acknowledged not only that there are some patients whose mental condition is such that they may remain confined in institutions for the rest of their lives but also that such confinement is clearly permissible under the statute. The Supreme Court has unanimously⁴⁴ held that the comparable federal statute, 18 U.S.C. §§ 4247-4248, which is applicable everywhere except in the District of Columbia, is valid as a proper exercise of Congressional power under the necessary and proper clause of the Constitution.⁴⁵ *Greenwood v. United States*, 350 U.S. 366 (1956); see *Royal v. United States*, 274 F.

⁴⁰ See, e.g., *Overholser v. Lynch*, 109 U.S. App. D.C. 404, 288 F. 2d 388 (1961), *rev'd*, 369 U.S. 705 (1962).

⁴¹ It is not clear what effect the 1966 amendment to 18 U.S.C. § 3568, and this Court's subsequent decision in *Stapf v. United States*, — U.S. App. D.C. —, 387 F. 2d 323 (1966), would have on such calculations, to name but one of the snares of such logic.

⁴² See *United States v. Charnison*, No. 3425, D.C.C.A. (pending), where Judge Kronheim ordered unconditional release because of the length of time since commitment under § 24-301(d), on a motion to revoke a conditional release after the patient returned to his previous criminal behavior, with uncontradicted testimony that it was a manifestation of mental illness.

⁴³ Corresponding release standards are provided for sexual psychopaths, in 22 D.C. Code § 3509; for civilly committed patients, in 21 D.C. Code §§ 546 and 548; and for mentally ill prisoners, in 24 D.C. Code § 303.

⁴⁴ With one Justice not participating.

⁴⁵ U.S. Const. art. I, § 8, cl. 18.

2d 846 (10th Cir. 1960). Remarking that the statute deals with mental disorder that is either temporary or "more than temporary,"⁵⁵ the Court in *Greenwood* observed that the writ of habeas corpus is "always available when circumstances warrant." 350 U.S. at 375. The statute, 18 U.S.C. § 4248, contains a proviso expressly permitting a patient to establish "his eligibility for release under the provisions of this section by a writ of habeas corpus." Identical language is found in 24 D.C. Code § 301(g). "Eligibility for release" simply means recovery to the degree required by the statute. The kind of treatment a patient may be receiving has heretofore been irrelevant to the habeas corpus court except in its determination of whether or not that treatment has yielded a positive result—i.e., recovery of the patient—for that alone is what may entitle him to release. That is the teaching of the statute.

Section 24-301 does not authorize "extending to [patients committed thereunder] confinement rights which the 1964 Act guarantees only to those civilly committed." *Cameron v. Mullen*, No. 20,308, D.C. Cir., decided March 2, 1967, slip op. at 16 (Bazelon, C.J.). Accordingly since such rights cannot be plucked out of the air they must be found, if at all, in the Constitution.

The broad sweep of the due process clause of the Fifth Amendment, which includes concepts of equal protection of the laws, *Bolling v. Sharpe*, 347 U.S. 497 (1954), would appear to require that confinement in a mental hospital may not be such that it "shocks the conscience," *Rochin v. California*, 342 U.S. 165, 172 (1952). If commitment under § 301(d) is at least in part for the purpose of 'providing treatment and cure for the individual,'⁵⁶ as well as "to effectuate Congress' basic concern . . . of reassuring the public,"⁵⁷ presumably some treat-

⁵⁵ In *Royal v. United States*, *supra*, the court held that the statute permitted the continued detention of one who is "permanently insane" and for whom there appears to be no chance of recovery. Some forms of mental illness, after all, are virtually untreatable.

⁵⁶ *Hough v. United States*, 106 U.S. App. D.C. 192, 195, 271 F. 2d 458, 461 (1959).

⁵⁷ *Lynch v. Overholser*, 369 U.S. 705, 718 (1962).

ment must be afforded. The accused, once found not guilty by reason of insanity, cannot just be thrown into a human storage bin. Complete lack of treatment may make continued commitment unconstitutional.⁵⁸ The defense of insanity may not "speak the word of promise to our ear and break it to our hope."⁵⁹

Very well, but we cannot consider the matter *in vacuo*. The Committee Reports on what is now § 24-301(d) state that, where an accused has successfully interposed the defense of insanity,

"It is just and reasonable * * * that the insanity, once established, should be presumed to continue and that the accused should automatically be confined for treatment until it can be shown that he has recovered."

S. Rep. No. 1170, 84th Cong., 1st Sess. 13 (1955); H.R. Rep. No. 892, 84th Cong., 1st Sess. 13 (1955). One who has been "confined for treatment until . . . he has recovered" should make a substantial showing of recovery before a court will consider possible lack of treatment as requiring release despite a failure to meet the statutory standards. Such a patient has been adjudicated to have committed an offense. *Rucker v. United States*, 108 U.S. App. D.C. 373, 280 F. 2d 623 (1960). It is only his mental condition which prevents society from protecting itself by imprisoning him. Instead, the law requires that he be confined in a different place, a hospital for the care and treatment of mental conditions, and society is entitled to the assurance that he will not be released until that condition has been sufficiently improved that, set at large, he will not require immediate recommitment. If the reasonable doubt as to his mental soundness which, at his behest, put him in the hospital, is not proved no longer to exist, he can only be released at the risk of making the criminal process, for him, a revolving door: that release will be followed only by new crime and new

⁵⁸ *Darnell v. Cameron*, 121 U.S. App. D.C. 58, 62, 348 F. 2d 64, 67-68 (1965).

⁵⁹ Shakespeare, *Macbeth* V. viii. 21-22. See Halleck, *The Defense of Insanity in the District of Columbia—A Legal Lorelei*, 49 Geo. L.J. 295 (1960).

commitment. That risk should only be taken, in the absence of such recovery, on clear proof that the institution is not trying to help the patient to recover.

At the very least, the patient must show that he has sought the means to recover and that he has been rebuffed, that he is trying to prevent a recurrence of his criminal behavior and not merely to beat the system. He must show that he has taken advantage of the opportunities for therapy which have been offered to him, and that further opportunities have been withheld from him so unreasonably that the Hospital can be said not to be trying *bona fide* to treat him. His confinement must be so lacking in treatment as not "to permit of constitutional differentiation" ⁶⁰ from incarceration, which is forbidden by his acquittal on insanity grounds.⁶¹

Section 24-301(d) creates an "exceptional class" of persons, requires their commitment until they have recovered from mental conditions which caused them to prey upon the community, and places on them a heavy burden of proof to establish their recovery.⁶² It would be outlandishly inconsistent to make a lesser *quantum* of proof sufficient for the release of an unreformed predator on the extra-statutory ground that he is not receiving treatment.

D. No appropriate judicial remedy can or should enforce a broader right to treatment

While the right only to so much treatment as differentiates a mental hospital from a prison may seem a narrow one, it is all that a court can enforce. Beyond that *quantum* of treatment, the separation of powers assigns to Congress' power of the purse, and to the discretion of the executive branch, the questions of how much treatment, and what treatment, a patient will receive. Not only the ancient and honorable doctrine

⁶⁰ *Rochin v. California*, *supra*, 342 U.S. at 175.

⁶¹ See text following note 56, *supra*.

⁶² *Collins v. Cameron*, *supra*, slip op. at 5; *Overholser v. Leach*, 103 U.S. App. D.C. 289, 291, 257 F. 2d 667, 669 (1958), *cert. denied*, 359 U.S. 1013 (1959); *Ragsdale v. Overholser*, 108 U.S. App. D.C. 308, 312, 281 F. 2d 943, 947 (1960).

of judicial restraint, which seems to have few friends at court these days, dictates no deeper inquiry into the operation of Saint Elizabeths; so, too, do the nature of the remedies available against the Hospital and the effect on both courts and Hospital of allowing judicial inquiry under *Rouse I* to continue.

Habeas corpus was the remedy invoked here, and it has also been denominated the usual remedy for involuntary mental patients in the District of Columbia.⁴³ Accordingly, we start with the great writ, traditionally a swift, but unsubtle, remedy for relief from egregiously illegal confinement.

Baxstrom v. Herold, 383 U.S. 107 (1966), on which appellant relies, is an example of the most ancient use of *habeas*, a challenge to confinement as invalid *ab initio*. See also *Lynch v. Overholser*, 369 U.S. 705 (1962); *Cameron v. Mullen*, No. 20,308, D.C. Cir., decided March 2, 1967; *Benton v. Reid*, 98 U.S. App. D.C. 27, 231 F. 2d 780 (1956). The writ has also been used to determine whether a person is confined in a place not justified by the terms of his commitment. *Miller v. Overholser*, 92 U.S. App. D.C. 110, 206 F. 2d 415 (1953). But comparing *Miller* with *Clatterbuck v. Overholser*, 107 U.S. App. D.C. 283, 287 F. 2d 137 (1960), teaches us that *habeas corpus* only lies to give relief from clearly illegal confinement, not to make minor adjustments or improvements in the quality of confinement. *Prince v. Klune*, 80 U.S. App. D.C. 31, 148 F. 2d 18 (1945), expands that teaching to *mandamus*, another prerogative writ. *Roberts v. Pegelow*, 313 F. 2d 548 (4th Cir. 1963), applies the doctrine to the modern equivalent of *mandamus* in federal courts, a suit for a mandatory injunction.

The prerogative writs have traditionally been the sole method by which executive administrative action may be judicially compelled, and the remedy has taken the shape of the rights it implements. Since *Marbury v. Madison*, 1 Cranch 137 (1803), and even before, the courts have only intervened to compel executive officers to perform clear legal duties, to do what the law says they *must* do. Neither *habeas* nor any other remedy has ever been available to compel an officer of the exec-

⁴³ *Stewart v. Overholser*, 87 U.S. App. D.C. 402, 186 F. 2d 339 (1950) (*en banc*).

utive branch to do what a court would like to have him do, or thinks he *ought* to do. For example, to confine a patient or a prisoner in a dilapidated facility with peeling paint, falling plaster, and no heat might be so irrational an allocation of public resources that a court would correct it, but a patient could scarcely compel the hospital either to paint his room a different color or to give him a different room. By the same token, a patient cannot ask a court to require the hospital to assign him a different ward psychiatrist, or to get him a particular psychiatrist. Lawyers and courts cannot tell qualified medical men how to do their jobs unless they can be shown to be clearly derelict in their duty to their patients.⁶⁴

The proceedings below are apt proof of the unfeasibility of litigating the adequacy of a patient's treatment beyond an inquiry into whether *any* treatment is being given, especially in the light of appellant's claims that those proceedings were defective.

The testimony below took the major part of four court days, to which the depositions of appellant's experts added about another. The last witness said he had spent twenty hours in attendance in the courtroom in connection with the case, Tr. 333, and he, a nursing assistant at the Hospital, had no occasion to spend additional out-of-court time preparing his testimony. Not only would all psychiatrist witnesses spend considerable such time preparing to testify in a "treatment" case, but at least one Hospital psychiatrist would stay in court throughout the hearing to assist counsel. Here, three psychiatrists (including the Superintendent), one psychologist, and two nursing assistants from the Hospital testified, taking away from the treatment of other patients the time involved in establishing of record the nature of the treatment afforded to one patient. The lack of equity in such a situation is manifest; even more manifest is the illogicality of litigating the adequacy of something whose adequacy is decreased by litigation. If every

⁶⁴ We do not deal here with such claims as discrimination among patients on constitutionally untenable or irrational grounds, *e.g.*, consciously excluding Negro patients from treatment, which would be litigable issues for rather different reasons.

lawyer appointed for a *habeas* petitioner in Saint Elizabeths litigated the issue of treatment at half the length it consumed here, the Hospital would devote a ridiculous amount of its professional resources to those 150 or so litigants,⁶⁵ with no therapeutic benefit to *any* of its patients. We might as well permanently assign a judge to Saint Elizabeths,⁶⁶ or move the offices of the John Howard Pavilion psychiatrists, whose patients file the vast bulk of the Hospital's *habeas* petitions,⁶⁷ to the courthouse. If, as appellant avers, the seven psychiatrists presently assigned to John Howard now spend about a third of their time in court⁶⁸ or preparing for court, what useful purpose could be served by still further reducing the time they have available for the treatment of patients, by taking still more of it for litigating the adequacy of treatment? Assuming that ten psychiatrists are previously needed in John Howard, and that there are presently seven, a reaffirmation of *Rouse I* would increase the need to twelve. That would be judicial interference with the executive with a vengeance.

Accordingly, appellee submits that a patient mandatorily committed to Saint Elizabeths Hospital under 24 D.C. Code

* Using calendar 1965 and 1966 as reference points, one may say that about 200 *habeas* petitions emanate from Saint Elizabeths annually (about half from the 5% of the hospital population committed under 24 D.C. Code § 301(d), and about one quarter from the 90% under civil commitment). On about 150 of those, the writ issues and a hearing is set down; and perhaps 125 are actually heard by the District Court. That many ten-hour hearings would take 1,250 hours, approximately the entire annual calendar of one District Judge.

At present, Saint Elizabeths *habeas* hearings usually consume more than half and less than all of the Monday court day of one of the Motions judges. (Statistics based on (a) counsel's check of over 400 *habeas* jackets, and (b) substantiating, if slightly different, figures prepared by the Registrar of Saint Elizabeths Hospital.)

* Dr. Cameron has offered to fit out a large room at Saint Elizabeths as a courtroom for *habeas corpus* and civil commitment hearings.

* 130 of 220 petitions in 1965, and 91 of 172 petitions in 1966 by Saint Elizabeths patients whose place of detention within the Hospital could be readily determined came from John Howard. 76 of the 102 hearings held on such petitions filed in 1965, and 56 of the 82 held on those filed in 1966, were for John Howard patients. (Statistics derived from a check of *habeas corpus* jackets in the Special Proceedings Unit of the United States Attorney's office.)

* Dr. Cameron's estimate, 2 Tr. 52.

§ 301(d) ⁶⁰ is not entitled to *habeas corpus* relief on the ground that he is not receiving adequate psychiatric treatment unless he can show such an absence of treatment that the hospital is indistinguishable from a prison, having shown that he has recovered sufficiently from his abnormal mental condition that his further hospitalization is not required to protect the public.

II. Appellant's treatment was adequate under the appropriate standards

There can be little question that the treatment afforded to Charles Rouse at Saint Elizabeths Hospital met the constitutional standard which appellee here urges the Court to adopt for such cases. Even if that standard is not adopted—if this case is to be judged according to the criteria set up by *Rouse I*—appellee submits that Rouse's treatment has not been shown to be defective. Not only are appellant's arguments based on his misapprehension that the Hospital has the burden of proof on adequacy of treatment, but they lack objective data to support them. The Hospital demonstrated that its staff and facilities comply with all the objective criteria of adequacy presently available. Appellant cannot successfully challenge the finding below on this point, and he conceded below that the treatment afforded him was appropriate to his condition. His case rests on subjective judgments of the attitudes of the Hospital's staff, the nature of his relationship with his ward psychiatrist, and similar matters, by two expert witnesses who did not agree among themselves, had insufficient data for such subtle determinations, and failed to give the court an objective basis for overturning the medical and administrative discretion of the psychiatric staff of Saint Elizabeths Hospital.

⁶⁰ We do not deal here with the rights of persons civilly committed under 21 D.C. Code § 545 or its predecessors, who are provided a specific remedy for periodic review of their commitments in the committing court under § 21-546. That court's power to order "hospitalization * * * or * * * any other alternative course of treatment," § 21-545(b), may well include the power to modify a commitment in a Section 546 proceeding, which is apparently a continuation of the proceeding instituted by the petition for civil commitment. See *Lake v. Cameron*, 124 U.S. App. D.C. 264, 364 F. 2d 657 (1966). Section 24-301(d) contains no similar language, although the committing court's power to order conditional release under § 24-301(e) would in some cases be appropriate.

A. Staffing was numerically adequate

Appellant contends that the John Howard Pavilion, where he was confined at the time of the hearing, was inadequately staffed. This contention is either erroneous or disingenuous. The record was clearly to the contrary.

Appellee established the numbers of patients and of various types of personnel in John Howard, and the ratios between them, through his Exhibit 3 and by his own testimony, 2 Tr. 7-100.

Exhibit 3, which compares those staff-patient ratios with the ratios recommended by the 1958 APA STANDARDS, Exhibit 2, is set forth in full in Appendix A, hereto. This, it will be noted, reproduces the relevant part of page 61 of the STANDARDS, omitting ratios for "Geriatric," "Medical & Surgical," and "Tuberculosis" services.¹⁰ Dr. Cameron indicated his dissatisfaction with the STANDARDS as obsolete and badly drafted, 2 Tr. 12, 48, but noted that no others were available. 2 Tr. 12. Appellant underlines Dr. Cameron's dissatisfaction, but ignores his own witness' statement that the STANDARDS "are the less obsolete because of the development of * * * Milieu Therapy than they would be if central reliance still had to be placed on individual and group psychotherapy," Zwerling Dep. 48. This was highly significant, as Milieu Therapy was the basic mode of treatment operative upon appellant. Dr. Cameron stated his opinion that the staff and facilities of the John Howard Pavilion were "not ideal," but that

The facilities are reasonably good. The staff is adequate to be able to provide most of our patients a reasonable amount of treatment. 2 Tr. 18.

¹⁰ Appellant argues that "the 'continued treatment' category is a polite euphemism for * * * back-ward custodial care," Brief, p. 66. This is rebutted by the inclusion of a "geriatric" category, which requires fewer therapeutic personnel than "continued treatment." It should also be noted that appellant's statement in that footnote, that "virtually none" of the patients in John Howard Pavilion are "chronic cases requiring only custodial attention," has no support in the record. But appellant's error may lie in his belief that the STANDARDS "presuppose two categories," rather than five, of patients. Although the record does not explicitly so state, John Howard, as a maximum security facility, would of course have few "geriatric" patients. See the definition of "continued treatment" quoted in note 77, *infra*.

Dr. Zwerling admitted he could not evaluate whether appellant's ward was "adequately staffed," but said he "would be inclined to guess" that it was, on the basis of Dr. Cameron's testimony that the relevant "staffing pattern * * * comes close to the recommendations" of the APA, and that "with regard to nursing staff personnel, the ratios" were "in much more favorable." Z. Dep. 61-62. This, too, is ignored by appellant, who attacks his own witness' conclusion that Dr. Cameron's testimony showed substantial compliance with the APA STANDARDS, and the STANDARDS themselves, but offers no alternative standards.⁷¹

Appellant's attack is misplaced and misinformed. He places great emphasis on a discrepancy between John Howard and the APA ratio for "Physicians" to Patients, but that discrepancy is more imagined than real. It is based upon some interesting "calculations to take into account * * * two factors," (1) that the number of *psychiatrists* in John Howard is 7, not 8.7, although the APA refers to "physicians" in such a way that it is obviously does not just mean "psychiatrists,"⁷² and (2) that those psychiatrists "have unusually heavy obligations to appear in court," although the STANDARDS, p. 60, "refer to the number of personnel actually employed, without further reference [beyond leave allowances] to time not on duty" (emphasis in original). See Appellant's Brief, p. 67. Thus the Hospital's calculation of one doctor per 41 patients⁷³ in John

⁷¹ Although Dr. Zwerling stated that "there are generally accepted standards in the psychiatric community as to [the ratio of] the nursing staff as made up both of nurses and of nursing aides and ward attendants [to patients] in an environmental * * * therapy program," Z. Dep. 60-61, those were not developed by appellant.

⁷² Both words are used in the STANDARDS. *E.g.*, "The superintendent * * * should be a well-qualified physician and an experienced psychiatrist * * *," p. 9.

⁷³ To be precise, 1:40.6 or 2.47 doctors per 100 patients. This may be compared with the national average in 1964 of 0.97 (median : 0.84) per 100 patients, and the fact that only three relatively small states had better ratios at that time (Kansas, 3.75; Iowa, 3.70; Alaska, 2.77). Kanno & Glasscote, *FIFTEEN INDICES: an aid in reviewing state and local mental health and hospital programs* 11 (1966 ed.) (hereinafter cited as *FIFTEEN INDICES*). "It is important to note that many physicians working in mental hospitals (and included in these ratios) are not psychiatrists," *id.* at 10. [Counsel's inquiry of Dr. Glasscote's office revealed that residents are included, but interns are not.]

Howard is calculated on the same basis as the STANDARDS while appellant's estimate of 1 to 75 is based on inapposite calculations.⁷⁴ Appellant also compares that ratio for John Howard to the APA ratio for "Admission and Intensive Treatment," which clearly does not apply to all 354 patients in John Howard,⁷⁵ or to all twelve of its wards. Had appellant consulted pp. 13-14 of STANDARDS, he would be familiar with the APA's definitions of "Admission and Intensive Treatment"⁷⁶ and "Continued Treatment"⁷⁷ services in public mental hospitals. As

⁷⁴The mathematics of appellant's estimate are not stated in his brief, but evidently consist of the following: 7 psychiatrists to 354 patients=1:50; if they spend one third of their time elsewhere, 2/3:50=1:75.

⁷⁵This figure in appellee's Exhibit 3, Appendix A, reflects the building census of both resident and non-resident patients as of midnight December 8, 1966. It is not clear from STANDARDS whether this figure is more or less appropriate than the census of 341 resident in-patients on the same date. Although the figure of 354 is evidently not relevant to the tables in FIFTEEN INDICES, which refer to resident patients, it has been used throughout this brief in comparisons with those tables.

[The Hospital's month-end census figures for John Howard varied from a low of 318 to a high of 356 resident patients in 1966, with an average of 338 and a median of 336.]

⁷⁶*Inter alia*,

The plan of operation for such a Service provides for the early evaluation of prognostic factors in individual patients, with prompt transfer of those who will need extended care. The goal of this service is the early recovery and/or rehabilitation of patients within a period of approximately six months.

STANDARDS 14; see also *id.* at 28:

The Admission and Intensive Treatment Service in a private psychiatric hospital will vary with the goals of the institution and the types of patients accepted for care and treatment. The overall purpose of this Service is the early diagnostic evaluation of the individual patient in order to determine the prognosis and the measures that are needed for bringing about early rehabilitation and recovery.

Proper facilities for all modern therapies should be provided. Does Dr. Cameron's "arbitrary" assignment of all patients in the Hospital for less than a year to this category overstate its size, in view of the six-month figure here?

⁷⁷This service cares for patients who, on admission, require extended treatment or who have failed to respond to treatment in the Admission and Intensive Treatment Service * * *. Wards for disturbed, suicidal and convalescent patients should be provided so as to permit classification of patients according to their behavior.

STANDARDS 14; see also *id.* at 28:

Where provided [in a private psychiatric hospital], this Service cares for patients who are expected to need unusually prolonged treat-

the testimony of Dr. Cameron and Dr. Owens revealed, John Howard is an amalgam of both, and comparing it to the APA ratios, stated for both, thus requires either a lumping of the ratios to fit John Howard or a division of the patients and staff to fit the ratios. Only a small proportion of John Howard's patients can definitely be classified as "admission or intensive treatment," those approximately fifty "in the * * * diagnostic phase, rather than the treatment phase of their admission."⁷⁸ The other 300 all but defy classification save on the arbitrary length-of-stay distinction used in Exhibit 3, with the possible exception of the 80 to 90 patients⁷⁹ on wards 10, 11, and 12, the top-floor, so-called "disturbed" wards. Even they are not so easily categorized. Accordingly, Dr. Cameron divided the John Howard population by putting those hospitalized for over a year in "continued treatment." He himself admitted it

ment. Facilities for disturbed, suicidal and convalescent patients should be provided so as to permit classification of patients according to their behavior. Modification of the personnel ratios given may be made in accordance with specific needs.

The phrase "where provided" reflects the fact that some private hospitals exclude chronic and "assaultive or agitated" patients; that the average length of stay in private hospitals is 60 days, "suggesting that their predominant mission is brief treatment;" that state and local laws in some jurisdictions limit the length of patients' stays in such hospitals; and that some hospitals limit patients' stay by internal policy. Kanno & Glasscote, *PRIVATE PSYCHIATRIC HOSPITALS: A NATIONAL SURVEY* 11, 15, vi. 13 (1966). This accounts in part for the transfer of over 3,000 patients from particular private psychiatric hospitals to other facilities, over 1,600 of them to state mental hospitals, in 1964. *Id.* at 21-22.

Psychiatric services in general hospitals are also usually intended to provide "skilled diagnostic and consultation services and expert intensive short-term therapy." *STANDARDS* 34. They report an even shorter average length of stay, and more frequently limit the length of stay, than private psychiatric hospitals. Glasscote & Kanno, *GENERAL HOSPITAL PSYCHIATRIC UNITS: A NATIONAL SURVEY* (1965).

⁷⁸ Testimony of Dr. Owens, 2 Tr. 269-70. Dr. Owens evidently refers to those committed for determination of their mental condition in criminal cases, under 24 D.C. Code § 301 (a).

⁷⁹ This is an estimate. John Howard has 12 wards, and 354 patients come to an average of 29.5 patients a ward. Dr. Economon testified that Ward 8, on the floor below, had "about 22, no more than 23 patients," with "a capacity of 29 beds," 2 Tr. 175, out of the service's capacity of 396 beds. It is not clear from the record whether the additional patients (12×23=276) are assigned to more secure wards, such as 10, 11, and 12, or to the less secure wards on lower floors. Dr. Economon indicated that he supervised "somewhere near 80" patients, 2 Tr. 154, on three wards, including Ward 11.

was "an artificial distinction," created "to present data comparable to the APA standards." 2 Tr. 12.⁸⁰ Appellant, having formulated no better distinction, insists that the Hospital must comply with the highest APA standard, that for "intensive" treatment facilities. He cannot otherwise avoid the clear conclusion that the doctor-patient ratio of John Howard Pavilion, like almost all other relevant staffing ratios, equals or exceeds the STANDARDS published by the American Psychiatric Association.

That is not all. Appellant concentrates on the ratio of psychiatrists to patients, although his own witness, Dr. Zwerling, evidently thought that it was the adequacy of nursing attendant staff, not of psychiatric staff, that was significant.⁸¹ And in that particular, as he noted, John Howard vastly exceeded the APA standard of 1:4 for *intensive* treatment, with a ratio of 1:2 for the entire service.⁸² The only categories in which John Howard was seriously deficient⁸³ were (1) Registered Nurses for intensive treatment patients (1:30 rather than 1:5), and (2) laboratory technicians (1:28,000 procedures per year, hospital-wide, rather than 1:7500). No relationship between lab technicians and therapy was shown below, and as to the nurses, the substantial margin in attendants, or nursing assistants, more than counteracted this deficiency, which was only part of an overall sufficiency of patient-care personnel.⁸⁴

⁸⁰ See also 2 Tr. 48:

* * * in order to find some rational way of dividing patients so that the staff-patient ratios could be compared with the APA standards which are written in that form, it was necessary for us to make some sort of arbitrary division. We chose one year. This is part of my problem with the standards. I don't like the way they are written.

⁸¹ Z. Dep. 61. Dr. Zwerling also admitted he knew of no "recommendation widely held as standard" "as to the ratio of psychiatrists to patients in an environmental therapy program," Z. Dep. 62. Pp. 63-68 of appellant's Brief read somewhat hollowly in such perspective.

⁸² Precisely, 1: 2.17, or 46 per 100 patients.

⁸³ Although STANDARDS gives a ratio for hydrotherapists, this mode of treatment has evidently been completely superseded since 1958. The Kanno-Glasscote NATIONAL SURVEYS do not even mention it.

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Although Judge Holtzoff declined to view FIFTEEN INDICES, *supra*, on the ground it was not in evidence as an exhibit, 2 Tr. 355, appellee submits to this Court that it establishes beyond peradventure that the degree of compliance with the APA STANDARDS shown by Exhibit 3 is most unusual. John Howard's 1:41 doctor-patient ratio stands extraordinarily high in the national range from 1:27 to 1:345 for public mental hospitals. The national average of 1:103 (0.97 per 100) and median of 1:119 (0.84) are not far above the APA recommendation for "Continued Treatment" and "Geriatric" Services, 1:150—or 0.67 doctors per 100 patients, a figure which 13 states cannot match.³⁵ Four states do not have as many patient-care personnel as John Howard has physicians, 2.47 per 100 patients.³⁶

Thus appellant, unable to marshal any general accepted standards which can impeach Saint Elizabeths' staffing practices, must attack the Hospital for not having achieved goals it has set for itself—for not having a staff vastly in excess of the APA STANDARDS for the most intensive care. Dr. Cameron's goal of 6 or 7 psychologists, for example, would mean a 1:59 or 1:50 psychologist-patient ratio, against 1:100 recommended by the APA for "Admission and Intensive Treatment" Services. All the *desiderata* outlined by Dr. Cameron would produce the following total of patient-care personnel:

Physicians	9
Psychologists	6 (or 7)
Registered Nurses	22
Occupational Therapists	15
Others	9 (or 10)
Social Workers	6

87

term includes "physicians, psychologists and psychometrists, psychiatric and other social workers, registered nurses, and occupational and other therapists"). The total of 33 such persons in John Howard (see Appendix A) work out to 9.3 per 100, a figure exceeded in only four states: Alaska, 26.8; Iowa, 14.8; Kansas, 14.5; and Utah, 9.5.

³⁵ When STANDARDS was last revised, in 1958, the national average was 0.68, the median 0.60. The figures for 1956 were 0.60 and 0.50—or 1 physician per 200 patients. Only three states and D.C. then had more than 1 physician per 100 public mental patients. FIFTEEN INDICES 11.

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⁸² Dr. Zwerling also admitted he knew of no "recommendation with regard to the ratio of psychiatrists to patients in an emergency hospital." 2 Tr. 12. Pp. 63-64 of appellant's Brief re: 2 Tr. 12.

⁸³ Prec. 10.

⁸⁴ App. 10.

Although Judge Edwards relied on the FIFTEEN INDICES which, on her motion, was introduced as an exhibit, I Tr. 155, appellee submits to the Court that it establishes beyond peradventure that the degree of compliance with the APA standards shown by Exhibit 3 is most unusual. John Howard's 1:41 doctor-patient ratio is only slightly higher than the national range from 1:27 to 1:245 for public mental hospitals. Any hospital average of 1:13 (9.17 per 100), and median of 1:119 (0.84) are not far above the APA recommendation for "Continued Treatment" and "Geriatric" Services, 1:150—or 0.67 doctors per 100 patients, a figure which 13 states cannot match. Four states do not have as many patient-care personnel as John Howard has physicians, 24.7 per 100 patients.

Thus, appellee is unable to establish any general accepted standards which can impeach Saint Elizabeth's staffing practices, least attack the Hospital for not having achieved goals it has set for itself—for not having a staff vastly in excess of the APA standards for the most intensive care. Dr. Cameron's goal of 5 or 7 psychologists, for example, would mean a 1:59 or 1:50 psychologist-patient ratio, against 1:100 recommended by the APA for "Admission and Intensive Treatment" Services. All the desiderata outlined by Dr. Cameron would produce the following total of patient-care personnel:

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which includes "physicians, psychologists and psychometrists, psychiatric and other social workers, registered nurses, and occupational and other therapists". The total of 67 such persons in John Howard (see Appendix A) work out to 43 per 100, a figure exceeded in only four states: Alaska, 208; Iowa, 146; Kansas, 145; and Utah, 95.

When STANDARDS was last revised, in 1958, the national average was 0.68 per the median 0.60. The figures for 1958 were 0.60 and 0.50—or 1 physician per 200 patients. Only three states and D.C. then had more than 1 physician per 100 public mental patients, FIFTEEN INDICES (11, 25.)

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Social Workers	■

67

term includes "physicians, psychologists and psychometrists, psychiatric and other social workers, registered nurses, and occupational and other therapists"). The total of 33 such persons in John Howard (see Appendix A) work out to 9.3 per 100, a figure exceeded in only four states: Alaska, 26.8; Iowa, 14.8; Kansas, 14.5; and Utah, 9.5.

⁸⁵ When STANDARDS was last revised, in 1958, the national average was 0.68, the median 0.60. The figures for 1956 were 0.60 and 0.50—or 1 physician per 200 patients. Only three states and D.C. then had more than 1 physician per 100 public mental patients. FIFTEEN INDICES 11.

⁸⁶ FIFTEEN INDICES 13. (And one state has only 2.5.)

For 354 patients, this is 18.9 professional patient-care personnel per 100 patients—a figure exceeded by only one state, Alaska (26.8) in 1964, and over half again the highest such ratio in the nation at the time the goals were projected.⁸⁷

If the patient-staff ratios at John Howard Pavilion are inadequate “in the light of present knowledge,”⁸⁸ and if adequate treatment cannot be given without such staffing, as appellant implies, Brief 67-68, one wonders how many public mental hospitals can possibly give “adequate” treatment. By no standards except its own and those of appellant’s imagination has Saint Elizabeths Hospital been backward in providing people to treat appellant. There is no substantial question that his treatment has been adequate by the only completely objective criterion, numerical adequacy of staff.

B. Other objective data corroborated the staffing ratios

Appellee does not contend that adequacy of treatment can be decided solely on the numerical adequacy *vel non* of the relevant staff. Appellee himself testified that adequate staff can give inadequate treatment to a particular patient, and *vice versa*. 2 Tr. 52, 107. But numerical adequacy of staff and of physical facilities⁸⁹ is probative, as are such matters as accreditation which can be objectively proven one way or the other.⁹⁰ Al-

⁸⁷ FIFTEEN INDICES 13. In 1962 Kansas had 12.0 professional patient-care personnel per 100 patients.

⁸⁸ *Rouse I*, 373 F.2d 456.

⁸⁹ Dr. Cameron testified that John Howard Pavilion meets the Physical Standards set forth in STANDARDS, Appendix A, p. 59. 2 Tr. 10. It was not disputed that the physical facilities are adequate. See Zwerling Dep. 39.

⁹⁰ Dr. Cameron testified that Saint Elizabeths is accredited by the Joint Commission on Accreditation of Hospitals, composed of the American College of Physicians, the American College of Surgeons, the American Hospital Association and the American Medical Association, 2 Tr. 24, 27, 29. He also gave the following figures on numbers and percentages of mental hospitals, accredited and non-accredited, as of 1965, 2 Tr. 25-26:

	Acc.	Non. Acc.	Total
Public hospitals (exclusive of federal institutions)-----	103 (32%)	223 (68%)	326
Private hospitals-----	76 (48%)	85 (52%)	161
Totals -----	179 (37%)	308 (63%)	487

The 32% figure for public mental hospitals is corroborated in Kanno & Glasscote, PRIVATE PSYCHIATRIC HOSPITALS, *supra*, at 5. Of the private hos-

though deemed it "important" as indicating the Hospital's high position relative to other public mental hospitals. 2 Tr. 411.

Compliance with such standards as those of the APA and the Joint Commission on Accreditation,²¹ if not conclusive, can be objectively shown. Beyond the numbers game and the somewhat broad contours of accreditation,²² however, one enters increasingly murky areas of medical opinion: is the patient receiving appropriate treatment for his individual mental condition? and is that treatment, if appropriate, being properly carried out? The answer to the second question would appear to depend on adequacies of staff, and to that extent both to be objective and to refer back to compliance *vel non* with numerical staffing standards. As appeared below, that appearance is delusive, since the hard shell of fact, once penetrated, contains a soft mass of almost purely subjective matter. The more objective question here was whether the Hospital had used appropriate means for treating appellant, a point on which the Hospital prevailed almost by default.

pitals involved in that study, 79 said they were accredited, 59 were eligible but unaccredited, 7 were too small for accreditation and 4 wouldn't say. 57% of the 138 eligible, responding hospitals, and 53% of the 149 hospitals which had returned questionnaires in the study, were accredited. *Ibid.*

Dr. Cameron also said that "at least ten or fifteen" of the hospital's training programs are accredited. 2 Tr. 29. He was ambiguous on the significance of that vague figure: "Because of our rather large size we perhaps have as many, if not more, accredited training programs than most public hospitals. But * * * [most] university hospitals and things of this kind* * * certainly have accredited training programs in all * * * or nearly all of the areas, that we do; and certainly some * * * have * * * more." 2 Tr. 30.

"Appellee introduced both the Commission's Standard for Hospital Accreditation, Exhibit 5, and the Hospital's Survey Report compiled for its most recent accreditation inspection in 1965, Exhibit 6. Neither is specifically geared to the mental hospital.

"If 32% of public mental hospitals are accredited, and we can assume a fairly even distribution of such institutions throughout the country, FIFTEEN INDICES might give us some indication of what this means, since the 16th ranked of the 50 states in the tables in FIFTEEN INDICES would presumably have the staffing ratios of the thirty-second percentile of mental hospitals. Those ratios are 1.14 physicians, 5.9 professional patient-care personnel, and 47.2 "full-time employees" per 100 patients. Pp. 12-15. The 16th ranked state spends \$6.91 per resident patient per day. P. 17. (The relevant figures for the District of Columbia are 1.64 physicians [8th], 7.5 care personnel [10th], 63.1 employees [7th], and \$12.04 [3rd]. *Ibid.*)

C. Appellant received appropriate treatment for his condition

Whether the treatment afforded a patient is appropriate to his needs is not always easy for a layman to determine; psychiatrists will often differ among themselves on this point, leaving the court to decide between conflicting experts.⁹³ A panel of this Court has applied to this problem a standard from the field of administrative law, which appellee submits is peculiarly appropriate here and should be adopted by the full Court:

We do not suggest that the court should or can decide what particular treatment this patient requires. The Court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.

Tribby v. Cameron, No. 20,454, decided April 14, 1967, slip op. at 3 (Edgerton, J., joined by Robinson, J., with Tamm, J., concurring in result).⁹⁴ Here, as in administrative agency cases, an expertise beyond that of a court—the experience, skill, and learning of the attending psychiatrists in their specialty—must be assessed. Moreover, their decisions on whether to give a particular form of treatment to one patient or another, when only one can be accommodated, involves the allocation of resources within the executive branch, a matter which courts have traditionally left to administrative discretion, and particularly to medical discretion. See *Prince v. Klune*, 80 U.S. App. D.C. 31, 32, 148 F. 2d 18, 19 (1945), where this Court held *mandamus* unavailable to compel a physician at the Lorton Reformatory to perform an admittedly needed operation on the prisoner—appellant, noting, as to the doctor's "discretion,"

It remains for him to decide * * * the effect upon appellant's fellow-inmates of diverting from them and de-

⁹³ E.g., in *Hemphill v. Cameron*, *supra*, there was substantial disagreement both between the patient's experts, and between their opinion and that of the Hospital, as to what would best suit the patient.

⁹⁴ As the excerpt suggests, the panel in *Tribby* remanded for a hearing on adequacy or treatment under *Rouse I*. The patient was, however, released, and his petition dismissed as moot, before such a hearing could be held.

voting to him the medical and nursing time and attention which the operation and necessary after-care would require. Courts are not equipped and cannot be called upon to try such questions.

In this case, the only dispute over whether particular treatment was appropriate for appellant was a peripheral one. At both hearings in H.C. 287-65, Dr. Economon testified that the basic mode of treatment for appellant was milieu, or environmental, therapy, and that other forms of treatment were used as adjuncts to the therapeutic milieu.²⁸

²⁸ Milieu therapy does not, as *Rouse I* evidently concluded, consist merely of "confinement in a hospital," 373 F. 2d 456. It is "a scientific manipulation of the environment aimed at producing changes in the personality of the patient," Cumming & Cumming, *EGO AND MILIEU: THEORY AND PRACTICE OF ENVIRONMENTAL THERAPY* 5 (1962) (hereinafter cited as *EGO AND MILIEU*). It implements the discovery that "the environment can *itself* be the primary treatment as well as supporting or complementing other treatment." *Id.* at 3. In contrast with the traditional forms of psychotherapy, which require highly trained personnel, milieu therapy is a system in which, under the guidance of such personnel, "relatively unskilled people can be trained to create a therapeutic milieu for patients with serious illnesses," *id.* at 1.

"The therapeutic milieu defines the patient as actor, initiator, cooperator, and manager of his own affairs and everyone else as assistants in this process. This is the most important single difference from the traditional treatment where the patient is the passive recipient of help * * *." *Id.* at 138.

Dr. Kraft succinctly described it as "very much like a school for living, where the patient is the student and the staff is the faculty and his whole life is the subject matter." K. Dep. 4; see also 3-8. Dr. Economon's description, 2 Tr. 155-162, was accepted by Dr. Zwerling, who also gave a short description, Z. Dep. 8-10.

At least in name, milieu therapy "is presently the basic method of treatment in most public mental hospitals," although "the extent to which milieu therapy actually exists, varies very widely." Zwerling Dep. 44; see also *EGO AND MILIEU* 271. There is some disagreement as to whether it is best supplemented by individual psychotherapy or by group therapy, which is perhaps traceable to "systematic differences in orientation" between milieu therapy practitioners with "a psychoanalytic approach" and those who "put a more primary emphasis on affecting [?effecting?] behavioral change in the expectation that this, in turn, will lead to intrapsychic change." Zwerling Dep. 68-71. The basic theories of environmental therapy have had several different practical applications, and further variations "are certainly possible." *Id.* at 79-80. Compare *EGO AND MILIEU*; Jones, *THE THERAPEUTIC COMMUNITY* (1953); Edelson, *EGO PSYCHOLOGY, GROUP DYNAMICS AND THE THERAPEUTIC COMMUNITY* (1964).

Appellant did not challenge the appropriateness of milieu therapy to his condition. Both his counsel and his experts conceded that point. See 2 Tr. 339. The central thrust of appellant's argument was that the milieu therapy applied to him was inadequate, see pp. 56-60, *infra*; but a side issue was what other modes of therapy would have been appropriate for appellant.

Particular emphasis fell on Rouse's discontinuation of group psychotherapy in February 1965, on whether group or individual therapy should have been again made available to him, and on which of them was more appropriate.

The Hospital records show that Dr. Agler, who preceded Dr. Economon as Rouse's ward administrator, recommended individual psychotherapy for Rouse in 1964, and that Dr. Economon supported this recommendation. On July 14, 1964, Rouse began group therapy with Dr. Borriello in a group of six patients,⁹⁶ which met twice weekly for 1½ hours,⁹⁷ until, on February 18, 1965, Rouse dropped out of group therapy.⁹⁸ 2 Tr. 272, 275. This was discussed within the group before he left, and Dr. Borriello told him both that the discontinuation was "very self-destructive" and "that he knew how to get in touch with me if

⁹⁶ 2 Tr. 278.

This is a proper number of patients for the type of group therapy administered by Dr. Borriello, note 98, *infra*. See Zwerling Dep. 69; Foulkes & Anthony, GROUP PSYCHOTHERAPY: THE PSYCHOANALYTIC APPROACH 19, 64 (2 ed. 1965).

Appellant's apparent disinterest in the size of Dr. Borriello's group is remarkable, since "group psychotherapists have always laid great stress on the question of numbers * * *. The aims of therapy dictate the necessary numbers, and numbers dictate the limits of therapy." *Id.* at 64.

⁹⁷ 2 Tr. 176.

These are both an accepted frequency and "the best workable time" for group therapy sessions. *Id.* at 67-68.

⁹⁸ Appellant evidently attached little importance to whether Dr. Borriello's particular type of group psychotherapy was appropriate for him, although both the record and the authorities show that there are four different principal schools of group psychotherapy, within which there are perhaps twenty distinct 'systems' of group therapy. 2 Tr. 280; Zwerling Dep. 40; Noyes & Kolb, MODERN CLINICAL PSYCHIATRY 517-19 (6th ed. 1963). See also Corsini, METHODS OF GROUP PSYCHOTHERAPY (1957). Under cross-examination by appellee, Dr. Borriello stated that this method was "predominantly non-directive," and "somewhat psychoanalytic in its orientation," but he considered it "eclectic", taking "from each school of thought the best, the most useful, the most beneficial for the patient." 2 Tr. 279, 281.

he wanted to resume therapy," 2 Tr. 278, but Rouse never did so, although Dr. Economon made efforts to get him to go back to Dr. Borriello or into group or individual therapy with another therapist. 2 Tr. 177.⁹⁹ This was a major bone of contention below.

Dr. Borriello stated that this type of "group therapy would not be effective if you compelled" a patient to take it, 2 Tr. 278. Rouse left the group because he "did not want to experience the discomfort involved in change," 2 Tr. 282.¹⁰⁰ Dr. Cameron stated regarding this, 2 Tr. 39:

One cannot give a person individual or group psychotherapy by giving him medicine and pouring it down his throat; he must participate and collaborate in the process. If he refuses, either because of willfulness or because of his illness, this makes individual or group therapy difficult in the extreme.

He added that a patient's refusal to cooperate or participate in a particular form of treatment appropriate for him is not "a valid reason for concluding" that the patient "is not receiving adequate or appropriate treatment," regardless of "whether the person refuses because of willfulness or refuses because of illness." 2 Tr. 40.¹⁰¹

For appellant, Dr. Zwerling agreed with this "provided some alternative mode of treatment were shown." Z. Dep. 63. He characterized Rouse's withdrawal from group psychotherapy as "quite usual" for a patient with his illness, feeling that the reason for it was "anxiety generated by the group therapy program." Z. Dep. 12-13. The "appropriate responses for the psychiatrist or other team leader" in Rouse's basic milieu therapy

⁹⁹ This does not include the informal approach by ward attendant Odie McGee, not a trained therapist, who "asked some patients if they would want to come to discuss a few problems on the ward, and Mr. Rouse said no." 2 Tr. 192, see also 196. Rouse's rejection of that approach is not without significance, being quite similar to his evident rejection of all therapeutic overtures.

¹⁰⁰ See also Dr. Economon at 2 Tr. 162: "Rouse * * * said he did not want to experience the anxiety and discomfort that self-understanding and change would provoke, and he left the group. Dr. Borriello is not possessed of a rope to lash him down to his seat."

¹⁰¹ This is also the position since taken by the American Psychiatric Association. See Appendix C, pp. 76-80, *infra*.

would have been to "make every effort to block the withdrawal and to confront the patient * * * with his behavior, and attempt then to achieve some understanding" of the bases for the withdrawal. Z. Dep. 12.¹⁰² Dr. Kraft similarly stated that "the most appropriate response would be a thorough discussion with the patient about this." K. Dep. 10. He also felt that the patient's anxiety might be sufficiently "alleviated through the use of drugs" that he could continue, although he could not state "[i]n the abstract" what the appropriate response would be beyond "the starting point" of "discussing it," *ibid.*

This testimony indicates principally a difference of approach between the experts, and perhaps a deeper philosophical difference as to how various modes of treatment should be offered to a patient, and how his refusal to accept proffered treatment should be handled, which also appeared in the analysis by appellant's experts of his rejection of occupational and recreational therapy. Dr. Zwerling evidently believed that Rouse's withdrawal from the group should have been discussed with him in the first instance by Dr. Economon, his ward administrator, whereas the Hospital felt that this was primarily a matter for the patient's group therapist. That reflects a difference in approach between a milieu therapy program which is integrated with the patient's group psychotherapy, and one in which such intensive therapy proceeds parallel to, but separate from, the operation of the basic therapeutic milieu. Saint Elizabeths evidently separates the two, as appears from its method of referring patients from all the Hospital's services to "a central place in the hospital," the Department of Training,¹⁰³ to see if "there is a therapist available," Dr. Cameron's description of the method of getting individual psychotherapy for a particular patient, 2 Tr. 74. In Rouse's case, it appeared that Dr. Borriello had consulted such a central listing; he then discussed the listed patients with their "administrative doctors," and, after an interview with Rouse, selected him as an appro-

¹⁰² See also Z. Dep. 42:

I cannot see how any program of environmental therapy could permit a patient to withdraw from any scheduled activity because of anxiety, without dealing intensively with this withdrawal.

¹⁰³ 2 Tr. 258 (Dr. Owens).

priate patient for the particular "group therapy that I was going to offer to him," having decided that he would benefit from it. 2 Tr. 272-73. When Rouse sought to withdraw, his withdrawal was handled in the same way as his original selection, by Dr. Borriello.¹⁰⁴ Further evidence of the independence of Dr. Borriello's work from that of the ward personnel appears from his not discussing Rouse's ward behavior with his ward staff, and discussing Rouse with Dr. Economon from time to time, but never "[i]n terms of content," i.e., they did not discuss what was revealed in group sessions. 2 Tr. 275-76.

It thus strongly appears from the record that Rouse was selected for group psychotherapy out of a number of patients for whom it appeared appropriate; that he participated in it for about eight months; and that he then withdrew from it, over the objections and against the advice of his therapist, after the ramifications of that withdrawal had been fully explained to him. He was told that the door to the group would be open whenever he cared to return, and left to decide whether to do so or to persist in self-destruction. Dr. Zwerling would have done it differently, and some psychiatrists would have tried to engage Rouse in individual psychotherapy, but one cannot conclude that the Hospital's handling of this matter did not reflect "a permissible and reasonable decision in view of the relevant information and within a broad range of discretion."¹⁰⁵

Appellant asks the Court to conclude that his treatment was inadequate because the Hospital allocated its limited assets, in terms of available therapists, to other patients, once he had shown a disinclination to cooperate, all of this in regard to forms of therapy in which the patient's cooperation is "essential." Appellee submits that this Court, like the court below, should decline appellant's invitation to substitute its discretion for that of Dr. Cameron, and to take over the internal management of Saint Elizabeths Hospital. There is no support in this record for a conclusion that appellant's treatment was inappropriate as a matter of law.

¹⁰⁴ "Mr. Rouse was confronted with what he was doing right within the group study * * *. It was discussed with him in the group." 2 Tr. 276.

¹⁰⁵ *Tribby v. Cameron, supra*, slip op. at 3.

D. Appellant failed to show that he had received inadequate treatment

As already noted, appellant did not seriously contend below that his treatment was inappropriate. He and his experts claimed only that he was not given adequate milieu therapy, in a qualitative rather than quantitative sense: in short, that the Hospital was doing the right thing the wrong way.¹⁰⁶

By making this extraordinarily narrow contention, appellant all but relieved the Hospital of whatever burden of proof it might have had on the issue of treatment. Perhaps the Hospital had the burden of showing that appellant was receiving treatment with a rational basis in psychiatric theory or practice, and appropriate to appellant's condition. See *Rouse I*, 373 F. 2d at 459; *Tribby v. Cameron*, *supra*. Appellant's new view of the case, however, all but conceded that the Hospital had discharged this burden, and put upon appellant the task of showing that a proper theory of treatment had been improperly executed.¹⁰⁷

Very simply, appellant did not sustain this burden. While one of his experts opined that Rouse's treatment was "severely inadequate," Zwerling Dep. 22, the other said that it "minimally" comported with generally accepted standards for milieu therapy. Kraft Dep. 19. In view of the evident lack of any published standards, the court below could only speculate as to which expert was right, give the Hospital the benefit of the doubt, and conclude that Rouse was receiving adequate milieu therapy.¹⁰⁸

¹⁰⁶ This was a considerable switch from appellant's insisting at the 1965 hearing that "failure to accord * * * any treatment at all is a violation of his constitutional rights," quoted by Judge Fahy, concurring, in *Rouse I*, 373 F. 2d at 461 (emphasis added).

¹⁰⁷ Of course, the mere fact that Saint Elizabeths' staff used certain methods of treatment would establish *prima facie* that those methods were valid, in view of "the enormously high regard in which [the] * * * Hospital is held generally by members of [the psychiatric] * * * profession," Zwerling Dep. 21-22.

¹⁰⁸ Dr. Cameron gave his "opinion as to what the components of a proper treatment program are," and "what questions * * * should be asked as to each component to determine whether adequate treatment in that sense is being given to a particular patient," 2 Tr. 33-38. He also related that opinion to the treatment program developed for appellant, in support of

Moreover, on closer examination neither expert opinion deserves the weight petitioner would attach to it.¹⁰⁹ Both doctors based their opinions on an interview with appellant, on perusal of the Hospital's records concerning appellant, on hearing part of the testimony concerning appellant's treatment, and on walking through Ward 8, the ward appellant then occupied at John Howard. Neither one discussed appellant, or his treatment, with the ward administrator, Dr. Economon, his former group therapist, Dr. Borriello, or any of the ward personnel charged with the day-to-day application of a program of milieu therapy. Neither heard the testimony either of Dr. Borriello or of Mr. Banks, the chief nursing assistant on appellant's ward.¹¹⁰ It is difficult to fault Judge Holtzoff's conclusion that they "did not have enough data to justify drawing an inference as to the adequacy or inadequacy of treatment," 2 Tr. 415. Their only direct data on the attitudes of nursing staff to patients on Rouse's ward came from the testimony of Odis McGee, one of the nursing attendants, Tr. 189-195. McGee's only specific testimony was on two points: (1) he had once been instructed "to try to engage Mr. Rouse in more activities on the ward," 2 Tr. 193, and (2) he had set up, on his own initiative, a "therapy group" of patients "to discuss a few problems on the ward," 2 Tr. 192. Whatever the indications in the nursing notes, these items did not connote custodial care. It is one thing to assess the merits of hospitals' applications for research grants from NIMH "exclusively on the basis of hospital records." Zwerling Dep. 6. Such records are doubtless prepared for research purposes, and with an eye toward submitting them

his general opinion that appellant's treatment was "adequate, even though not ideal." 2 Tr. 40-43.

This testimony has acquired considerable *nunc pro tunc* weight from the adoption of almost identical "basic considerations" for defining treatment and appraising its adequacy, in a position statement approved on February 6, 1967, by the American Psychiatric Association. That statement, published in 123 AM. J. PSYCH. 1458-60 (1967), is set forth in Appendix C hereto as an aid to the Court.

¹⁰⁹ The following is in no sense intended as reflecting on the qualifications of Dr. Kraft and Dr. Zwerling, both of whom are unquestionably highly qualified forensic psychiatrists.

¹¹⁰ Although subpoenaed by appellant, Mr. Banks was not called by appellant as a witness.

to NIMH with an application for a grant. It is quite another to assess the treatment afforded a patient, and in that process to make judgments about staff attitudes and doctor-patient relationships, on the basis of hospital records which were not, so far as we know, intended to reflect those matters.

Aside from their lack of factual basis for an opinion, the doctors' testimony also showed a lack of criteria with which to weigh those data, except for their own subjective estimations of what constitutes adequate milieu therapy. Dr. Zwerling, who found appellant's treatment "severely inadequate," admitted on cross-examination that as to nursing personnel "the staffing pattern" was "not an inadequate" one "in terms of numbers," and stated that he did not "know of a *recommendation* widely held as a standard with regard to * * * the number of psychiatrists in ratio to patients in a therapeutic milieu program," Dep. 61-62 (emphasis added). What he found defective, in summary, was the attitude of the ward personnel, and the relationship between appellant and his ward psychiatrist. And it should again be emphasized that he was judging these elements of the treatment program on the say-so of Rouse, a chronic liar, and without discussing with any of the ward personnel their attitudes toward their patients, or their instructions either as to such attitudes or as to the preparation of nursing notes.

Now, it is one thing to say that medical treatment was inadequate because a proper drug was given in an insufficient amount, or because an indicated operation or procedure was not performed. The facts can be readily shown, and expert opinion marshalled as to whether it was sound medical practice to do or to omit a certain matter; although the court in such a case must substitute its judgment for that of the treating physician, a court can reasonably be asked to do so. Malpractice, as a rule, involves an established medical disaster—the patient lost a leg, or developed a twitch, or died—and courts have long decided whether to shift the burden of disaster from the victim to another responsible party. On rare occasions, a court will even exercise a *parens patriae* function and order specific medical treatment to save a child's life over parental objections, but only where medical necessity is imperative.

Rather different considerations are involved, however, when ongoing psychiatric treatment is challenged. In some cases, failure to give a particular form of drug therapy might be malpractice as clearly as failure to perform an appendectomy. It might even be demonstrable that a particular dosage of tranquillizing drugs was excessive or insufficient for a particular schizophrenic patient. With some schizophrenics, for example, the beneficial effects of drug therapy, once administered, are obvious. But beyond that—once the patient has been properly diagnosed and his most overt symptoms brought under control so that the various forms of psychiatric therapy can be attempted—what constitutes proper treatment all but eludes objective analysis.

This case, and the particular malady of this appellant, aptly illustrate this. Sociopaths are notoriously difficult to treat, and were generally deemed untreatable until relatively recently. A professor of psychiatry testified before a Senate committee in 1961 that "there is no effective treatment for" the sociopath in a mental hospital,¹²¹ and the 1964 edition of another psychiatrist's popular presentation of the sociopath expresses doubt that "any methods [of therapy] available today would be successful with typical sociopaths. * * * There are really no appropriate remedies available."¹²² Noyes & Kolb,¹²³ perhaps the most widely accepted general text on psychiatry, is only slightly less pessimistic and, like Cleckley,¹²⁴ emphasizes the need for lengthy hospital confinement to achieve the basic changes in personality structure that such treatment, to be successful, must achieve.¹²⁵ Of course, this Court scarcely needs to be reminded that Antisocial Reaction is still not recognized as a mental illness by some psychiatrists (*e.g.*, Drs. Marland

¹²¹ Testimony of Dr. John R. Cavanaugh, May 4, 1961, in *Hearings on the Constitutional Rights of the Mentally III*, 87th Cong., 1st Sess. 141 (1961). Dr. Zwerling stated below that this statement was not "representative of a sizeable body of psychiatric opinion at that time," Z. Dep. 38-39.

¹²² Cleckley, *THE MASK OF SANITY* 477, 480 (4th ed. 1964). See generally *Id.* 472-482. Dr. Kraft would not recognize this work as authoritative, K. Dep. 27.

¹²³ Noyes & Kolb, *MODERN CLINICAL PSYCHIATRY* (6th ed. 1963).

¹²⁴ *Supra*, note 112.

¹²⁵ Pp. 464-65.

and Bunge, who testified below ¹¹⁶), and that Saint Elizabeths Hospital only officially recognized it as a "mental disease or defect" for purposes of the insanity defense in 1958. See *Blocker v. United States*, 107 U.S. App. D.C. 63, 274 F. 2d 572 (1959) (*en banc*).

Such being the state of psychiatric knowledge of the illness in question, and of its treatment, a court could scarcely be asked to conclude that a particular application of an apparently—and here, concededly—appropriate mode of treatment was inadequate. How, then, could such a court draw such a conclusion concerning the application of a mode of therapy that is in its infancy, proved in theory but not fully defined in method, capable of being "modified for the situation in any hospital," ¹¹⁷ and not even mentioned in the 1963 edition of one of the most authoritative texts in the field of psychiatry? ¹¹⁸ How can a legal conclusion be reached as to a matter so subjective that the two experts called by appellant differed in their medical judgment on it? How can such a conclusion possibly be based on conflicting opinions, one doctor finding the treatment "severely inadequate," ¹¹⁹ while the other says that it "minimally comports with" generally accepted standards for that mode of therapy, but that he "can't say" ¹²⁰ that it was adequate or inadequate?

That was appellant's case below. Appellee submits that Judge Holtzoff correctly refused to hold that such a speculative showing merited a finding that inadequate psychiatric treatment had been given to appellant, even under the standard created by *Rouse I. Parturient montes, nascetur ridiculus mus*. ¹²¹

III. The management of the treatment hearing reveals no ground for reversal

Appellant contends that the January, 1967 hearing was defective in various respects and that H.C. No. 287-65 should

¹¹⁶ 1 Tr. 46 (Marland) ; 2 Tr. 287, 298 (Bunge).

¹¹⁷ Cumming & Cumming, *Ego AND MILIEU* 84 (1962).

¹¹⁸ Zwerling Dep. 40, as to Noyes & Kolb, *MODERN CLINICAL PSYCHIATRY* (6th ed. 1963).

¹¹⁹ Zwerling Dep. 22.

¹²⁰ Kraft Dep. 19.

¹²¹ Horace, *ARS POETICA*, line 168.

be remanded for a third hearing before another judge. Most of the defects alleged by appellant are only such if the full Court reaffirms *Rouse I* and accepts appellant's argument that the adequacy of application of an admittedly appropriate form of psychiatric treatment can and should be determined in a *habeas corpus* hearing. Some of what appellant calls "defects" are inherent in the remedy he invoked, *habeas corpus*, so that he might as well be criticizing a grapefruit because it was not a very good orange. Other limitations on the proof below were imposed on both parties, and thus did not unduly prejudice appellant. And appellant clearly waived below some objections he now advances here.

A. The burden of proof was properly assigned

First, appellant claims that the burden of proof was improperly placed on him, as the moving party, on both issues, recovery¹²² and treatment. But appellant can cite only the somewhat inconclusive language of *Rouse I*, 373 F. 2d at 456,¹²³ and the inapposite decision in *Lake v. Cameron*, *supra*, to support the extraordinary suggestion that a moving party, solely by making a particular allegation, can place the burden of proof on the other side. A mere *prima facie* showing may in some instances shift the burden of proof, but *Davis v. United States*, 160 U.S. 469 (1895) (government must overcome "some

¹²² There is little question on this record that that appellant was still mentally ill, and dangerous by reason of his illness, at the time of the hearing. Dr. Cameron, Dr. Economon, Dr. Kraft, and Dr. Zwerling all agreed on the diagnosis; Dr. Economon and Dr. Zwerling testified to danger; and the supporting data were unusually full. Dr. Bunge's contrary opinion was hardly sufficient to tip the scales in appellant's favor, even if the burden of proof had been on the Hospital to show illness-linked danger beyond a reasonable doubt. Appellee accordingly deems it unnecessary to give the matter any extended discussion. Were it the only question involved, this would be an appropriate case for summary affirmance. Compare *Delaney v. Cameron*, Misc. No. 2963, D.C. Cir., decided March 2, 1967 (petition for leave to appeal *in forma pauperis*, denied); *Bresnahan v. Cameron*, No. 20,162, D.C. Cir., decided December 8, 1966 (reversed *per curiam* for appointment of an independent psychiatrist).

¹²³ The hospital need not show that the treatment will cure or improve [the patient] but only that there is a bona fide effort to do so. This requires the hospital to show that initial and periodic inquiries are made into the needs and conditions of the patient with a view to providing suitable treatment for him, and that the program provided is suited to his particular needs.

evidence" of insanity by proving sanity, as an element of the offense, beyond a reasonable doubt), is particularly suggestive of the usual duty of the party attacking the *status quo* to prove his case. Here, the legislative history of 24 D.C. Code § 301(d) indicates that appellant's "insanity, once established, should be presumed to continue,"¹²⁴ a clear mandate to the courts to require him to overcome that presumption to obtain his release. The decisions of this Court have uniformly so assigned the burden in *habeas* cases,¹²⁵ and the Supreme Court alluded to that requirement in holding that § 24-301(d) does not apply to an accused who does not interpose the defense of insanity. *Lynch v. Overholser*, 369 U.S. 705 (1962). As appellee has already suggested, *supra*, p. 37, it would be extraordinarily illogical to put the burden of proof on the *habeas* petitioner as to the grounds for release specified in the statute, § 24-301(e), but not as to a ground not so specified.

There should be a presumption that persons committed to the Hospital are receiving appropriate and adequate treatment. Such a presumption is suggested in *Tribby v. Cameron*, *supra*, and appellee strongly urges the full Court to make the existence of that presumption clear.

The Hospital will, of course, be able to show what treatment it is giving a particular patient. That is peculiarly within the knowledge of the attending psychiatrists.¹²⁶ But the fact that those psychiatrists, presumably qualified, apply that treatment should be *prima facie* proof of its efficiency, and the patient should be required to show that it is insufficient. Saint Elizabeths Hospital should not be required to justify its existence at

¹²⁴ S. REP. NO. 1170, 84th Cong., 1st Sess. 13 (1955); H.R. REP. NO. 892, 84th Cong., 1st Sess. 13 (1955).

¹²⁵ See, e.g., *Overholser v. O'Beirne*, 112 U.S. App. D.C. 267, 302 F. 2d 852 (1962); *Overholser v. Leach*, 103 U.S. App. D.C. 289, 292, 257 F. 2d 667, 670 (1958), *cert. denied*, 359 U.S. 1013 (1959).

¹²⁶ That is the only apposite holding in *Lake*, which seems, indeed, only to shift the burden of determining possible alternatives to hospital confinement in civil commitment proceedings, where the statute requires the consideration of such matters. Section 24-301(d) prescribes no such alternatives. Moreover, *Lake* only applies where the patient has first shown that release will not endanger the public: "Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection." 124 U.S. App. D.C. 220, 364 F. 2d 661.

the beck of every patient within its gates who may allege that his treatment is not what he thinks it should be.

B. Depositions were properly denied

Appellant's objection to the trial court's quashing his notice of deposition is not well taken.

First, appellant is dead wrong when he assumes that depositions are available under the Federal Rules of Civil Procedure in *habeas corpus* proceedings. The relevant statute makes them available, together with other similar devices, for the very limited purpose of establishing simple facts and making the presence of certain technical witnesses unnecessary at the *habeas* hearing. 28 U.S.C. § 2246 is not explicit on this point, but the possibilities for dilatory maneuvering which are implicit in the discovery rules would surely militate against their application to *habeas corpus* proceedings. *Habeas* has historically been reserved for summary determinations of the legality of confinement, and any decision introducing extensive discovery into *habeas* would be a two-edged sword, easily used against a petitioner whose machiavellian jailer could moot his petition by delay.

Secondly, appellant sought these depositions for assistance in litigating a right under the Hospitalization of the Mentally Ill Act, specifically § 21-562. As appellee has contended at length above and elsewhere,¹²⁷ civilly committed patients, to whom that right specifically applies, must primarily assert it under that Act; and the Rules of Civil Procedure are explicitly made inapplicable to such a proceeding by Rule 81(a)(1).¹²⁸ It would be most curious to allow a civil patient to circumvent that Rule by petitioning for relief under the secondary, extraordinary remedy of *habeas corpus*; it would be still curiouser to hold that a criminal patient, not explicitly covered by the Act, may assert rights under it in such a manner. Rule 81(a)(1) is, in any event, strong authority for refusing discovery in any proceeding in the District of Columbia involving mental health, including *habeas corpus*.

¹²⁷ *Dobson v. Cameron*, No. 80,573; *Stultz v. Cameron*, No. 20,576; *Brody v. Cameron*, No. 20,569.

¹²⁸ These rules * * * do not apply to mental health proceedings in the District of Columbia except to appeals therein.

Third, appellant's *habeas* petition is intrinsically an adjunct of the criminal case in which he was committed, so that the Civil Rules should be wholly inapplicable. Leaving aside the fact that the criminal case was in the Municipal Court, which applies them only when it acts in lieu of the Commissioner, the Federal Rules of Criminal Procedure give appellant no such broad-gauged discovery as he demands here. Rule 16, Federal Rules of Criminal Procedure allows a defendant to inspect medical reports, but appellant's counsel had full access to the Hospital's records. He was entitled to no more.

Fourthly, appellant's objection was largely nullified by Judge Holtzoff's ruling that he could take the testimony of expert witnesses by deposition. Appellant did not even take full advantage of that ruling, which allowed him three experts, 2 Tr. 123; he went forward with two. Incorrect as the ruling appears in the light of the discussion immediately above, it erased any prejudice to appellant from the denial of depositions. He could establish the factual case at leisure and then use that transcript, rather than the depositions he had previously sought, to prime his experts.

Fifth, appellant can scarcely claim prejudice on the record below. He surely waived the deposition of Mr. Banks, the supervising attendant on his ward, by having him present under subpoena and not calling him as a witness. Dr. Platkin was not called to testify by either party, rendering prejudice from lack of his deposition highly speculative. Dr. Owen's testimony revealed little reason to call him as a witness, let alone to depose him. And as to Dr. Economon, as Judge Holtzoff pointed out, appellant had the benefit of his testimony at the previous hearing. *Dancy v. United States*, 124 U.S. App. D.C. 58, 361 F. 2d 75 (1966), indicates that such testimony is an ample substitute for discovery. Judge Holtzoff's ruling that depositions would be unduly oppressive, in view of the prior hearing and the evident need to have the witnesses testify twice, was scarcely an abuse of the trial court's discretion to limit discovery under Rule 30, particularly in view of the effect on Saint Elizabeths of allowing such discovery in every case where a patient may seek to litigate the efficacy or adequacy of his treatment.

Sixth, appellant evidently only desired the depositions in question because of the extremely detailed inquiry into his treatment which, under the criteria established by *Rouse I*, he launched. Should the Court now disavow those criteria, his need for the depositions would seem to disappear *nunc pro tunc*.

C. Appellant was not unduly hampered in presenting his case

Appellant voices lengthy objections to Judge Holtzoff's "overt hostility" to his position and to the limitations the judge placed on his presentation of evidence. Brief, pp. 105-119. These objections are essentially indistinguishable, and flow from Judge Holtzoff's perception, which appellee submits was correct, that appellant sought to lead the court through an excessively detailed inquiry into matters of psychiatric expertise and discretion on which a court could not, and should not, pass judgment.¹²⁹

Judge Holtzoff frequently admonished counsel for wasting the court's time. He obviously did not expect the protracted hearing which eventually took place, and would have been even longer but for taking the testimony of Drs. Kraft and Zwerling by deposition. He rightly expected "an ordinary habeas corpus case," 2 Tr. 125, one that could be terminated in a day or less. 2 Tr. 3. Accordingly, he frequently admonished both counsel to keep their examination of witnesses short,¹³⁰ and even prevented appellee from recalling Dr. Economon at the end of the hearing. 2 Tr. 333-34. He eliminated considerable testimony by limiting the second hearing to what had occurred since the first hearing. 2 Tr. 108, 109-110, 117, 180. He indicated a desire both to conserve court time and to save the time of the staff at Saint Elizabeths by circumscribing the proceedings as much as possible. He did not cripple appellant's case, as appellant insists.

Appellant puts considerable stress on the court's limiting him to two expert witnesses "on the treatment question," making an

¹²⁹ See pp. 28-41, *supra*, on the proper scope of inquiry into the psychiatric treatment afforded appellant.

¹³⁰ In addition to the admonitions to appellant cited at p. 106 of his brief see those to appellee at 2 Tr. 75-76, 105, 111, 113-114, 119, 180, 185, 186, 187, 290-291, 300, 304, 306.

extensive representation as to the experts he did not call because of that ruling. Brief 109-110. Appellee submits that appellant waived his objection by not deposing a third expert after the court granted *his request* for such depositions and expanded his ruling to allow three depositions. 2 Tr. 121-123. Litigants cannot mousetrap a trial court into reversal.

Appellant then complains of the very deposition procedure that he espoused below. This extraordinary contention merits no reply, but it is also expanded into an assertion that appellant was prevented from presenting in full the testimony he had hoped to elicit from Dr. Kraft by the court's rulings when Dr. Kraft was on the stand. Appellee is quite mystified by appellant's urging at one point that the civil rules as to depositions apply to *habeas*, and at another point urging that a ruling on in-court testimony limited his examination of Dr. Kraft in such a deposition. Rule 26(b), Federal Rules of Civil Procedure explicitly allows taking by deposition "testimony . . . inadmissible at the trial," and has been construed to allow the very broadest kind of inquiry. The rulings made below on the admissibility of portions of appellant's depositions do not exclude them from this Court's consideration. Appellant cannot eat his cake and have it too.

Both parties were restricted in their presentation below. While Judge Holtzoff was at times impatient with appellant's counsel, he did not exceed judicial propriety or his discretion in controlling the evidence before him, a discretion especially applicable to proceedings without a jury. Appellant's disappointment at not litigating the adequacy of his treatment at even more copious length, while understandable in the light of his extensive preparation, does not rise to the level of prejudice requiring reversal.

IV. The District Court properly rejected appellant's claim that his commitment to Saint Elizabeths was invalid *ab initio*

In the second proceeding here under review, appellant challenges the legality *ab initio* of his confinement under 24 D.C. Code § 301(d), on a broad range of grounds running from alleged unconstitutionality of the statute to ineffective assist-

ance of counsel. Appellee continues to reply that only the most glaring jurisdictional objections may be raised on *habeas corpus* without prior recourse to the committing court or to direct appeal, and that none of appellant's contentions has merit.

~~A. Such contentions should first be addressed to the committing court if factual determinations are required~~

As appellee noted below, this Court had previously held that a prisoner serving sentence under judgment in a criminal case may not seek his release in *habeas corpus*, but must apply to the committing court if he alleges an invalidity in the criminal proceeding. *Pollen v. Preston*, No. 19,350, D.C. Cir., decided October 7, 1965. This Court has since reaffirmed that doctrine with special reference to a patient seeking release from commitment under 24 D.C. Code § 301(d). *Arduini v. Cameron*, No. 20,864, decided May 1, 1967 (dismissal of *habeas* petition without hearing summarily affirmed, *per curiam*, without prejudice to patient's pursuing presently available remedies in the Court of General Sessions and D.C. Court of Appeals).

Appellee submits that this decision merely restates the ancient nature of *habeas corpus* as an extraordinary remedy, only available when ordinary avenues of relief are no longer open. *Fay v. Noia*, 371 U.S. 391 (1962), teaches us that failure to exhaust previously available remedies need not be fatal to a *habeas* application, but holds by firm implication that presently available remedies in the trial court, or system of courts, must be exhausted.

This is a simple matter of comity, of letting a trial judge correct himself unless he was so egregiously wrong that his jurisdiction can be said to have been defective. In such circumstances, *habeas* may be appropriate, but only when the face of the proceedings shows a clear violation of rights. Questions of fact should be delegated to the trial judge for his consideration, not reversed by another judge; only on clear questions of law is *habeas* appropriate.

Thus, beyond his constitutional claim that § 24-301(d) is an impermissively irrational expression of the legislative will, and his equally jurisdictional contention that the face of the proceedings showed the statute to be inapplicable to him, ap-

pellant made no allegations cognizable in *habeas corpus*. *Lynch v. Overholser*, 369 U.S. 705 (1962); *Cameron v. Mullen*, No. 20,308, D.C. Cir., decided March 2, 1967, and *Cameron v. Fisher*, 116 U.S. App. D.C. 9, 320 F. 2d 731 (1963), stand for no more than that. Each involved allegations that the trial court's jurisdiction to commit was defective as a matter of law. Moreover, each arose in the context of the patient's also alleging his eligibility for release on the grounds of recovery, a question rendered moot by jurisdictional defects. Here, as in *Arduini*, the patient's mental condition was not in issue, having been determined so recently that the court would not reopen its prior inquiry.

Appellee accordingly submits that appellant's claims of ineffective assistance of counsel, which are particularly related to failure to pursue a motion to suppress evidence, were inappropriate matter for *habeas corpus*. Where the application of the statute rests on facts outside the trial record (or not stipulated, as in *Mullen*), the factual hearing should be before the trial judge.²²¹

B. Equitable considerations bar appellant's belated factual contentions

Moreover, appellant's factual claims should have been held barred by equitable considerations of *laches* and abuse of remedy.

Appellant was committed to Saint Elizabeths on November 9, 1962, almost six months after *Lynch* established the validity of his underlying legal contention, that his refusal to raise the insanity defense invalidated his commitment. *Cameron v. Fisher* had been in the news in 1963, and so had Judge Holtzoff's original decision in *Mullen* in May of 1966. Appellant had the assistance of counsel from the Legal Aid Agency,

²²¹ Allowing such matters to be litigated before a different judge raises the unseemly prospect of the trial judge being overruled on matters of which he has peculiar knowledge, such as whether his invariable practice has been to refuse to interpose the defense of insanity over the objection of the accused. Nor does it seem appropriate to by-pass the trial judge without allowing him to recuse himself. See *Starr v. Cameron*, H.C. No. 34-67, D.D.C., where Judge Matthews ordered release under *Mullen* despite a General Sessions judge's assurance that he had never interposed the defense of insanity "for" an accused.

to whom he had been referred because of counsel's experience in mental health matters, at least as early as January, 1965. 1 Tr. 77. He had three prior *habeas* cases, one of which had two hearings. Yet he slept on his rights and did not object to his continuing confinement save on the ground he had recovered and should be released, or on 'treatment' grounds.

This placed on appellant a heavy burden of showing that his factual contentions had not become stale to the extent that they were not preserved in the trial record, before he would be allowed to present them to a court. Appellee submits that he did not discharge that burden, and that his case should now be considered solely on the trial record.^{132a}

C. The mandatory commitment provision of 24 D.C. Code § 301(d) is not constitutionally defective

Appellant's contention that mandatory commitment to a mental hospital under 24 D.C. Code § 301(d) violates the due process clause has been rejected with monotonous regularity both by this Court and by the Supreme Court.

Since *Lynch v. Overholser*, 369 U.S. 705, 711 (1962), held that the statute, if applicable only to defendants who interposed the defense of insanity, was free from all but "insubstantial constitutional doubts," it might well be presumptuous of this Court to review it yet again. It was, moreover, subsequent to *Lynch* that this Court *en banc* last passed on the effect of § 24-301(d) on the operation of a criminal trial, holding that a trial judge's failure to instruct the jury that an acquittal on insanity grounds spells commitment under the statute is plain error. *McDonald v. United States*, 114 U.S. App. D.C. 120, 312 F. 2d 847 (1962). It should no longer be necessary to invoke the litany of cases upholding § 301(d) against constitutional attack in its early days.

This long line of consistent decisions is not overthrown by *Baxstrom v. Herold*, 383 U.S. 107 (1966), on which appellant

^{132a} A particular example of the inequities created by appellant's delay in presenting his factual claims is the increasing animosity of his former counsel against the United States Attorney's office, of which this Court has ample proof in briefs, motions, and other pleadings filed here in Nos. 19,562 and 20,827. The Government could scarcely be expected to call such a witness, even to refute claims he had given ineffective representation.

mistakenly relies. *Baxstrom* holds that procedural rights in civil commitment proceedings cannot be arbitrarily withheld on the basis of wholly irrational distinctions such as past criminal convictions, a simple application of the principle that bad people have rights, too. It also holds that similar distinctions among persons once they have been civilly committed are similarly untenable. The words "civilly committed" recur throughout the opinion, which found no "semblance of rationality" in the distinction between ex-convicts and "all others civilly committed." *Id.* at 115.

The obverse side of the *Baxstrom* coin is *Specht v. Patterson*, 386 U.S. 605 (1967), which held that "a new finding of fact" having the consequence of indefinite commitment, rather than a simple sentence for months or years, cannot be added to a criminal conviction without an adversary proceeding. See also *In the matter of Gault*, 386 U.S. —, 87 S. Ct. 1428 (1967). None of these cases infectiously invalidates a distinction between criminal and civil commitment.

That, however, is appellant's contention, that a self-sought finding that one has committed criminal acts because of a mental illness does not permit the community to insure against immediate repetition of the criminal behavior by subjecting the actor to confinement in a mental hospital until it is reassured that such repetition will not occur. *Lynch* explicitly sanctions this insurance against use of the criminal process as a revolving door, preventing the culprit from committing a continuous series of similar acts and obtaining an equivalent series of insanity acquittals *ad nauseam*. 369 U.S. 710-711. *Cameron v. Mullen*, No. 20,308, D.C. Cir., decided March 2, 1967, only extends *Lynch's* holding that such sanctions are inapplicable to defendants who do not interpose the defense of insanity, by taking the Supreme Court at its word and refusing to find authority in § 24-301(a) for a mongrel proceeding, a cross between § 301(d) and civil commitment, which is not mentioned in the statute. *Baxstrom* gives instructions that such a mongrel has no place in the purebred world of due process, and that commitment must be all one or all the other—a precept not violated by § 24-301(d).

Thus no recent developments compel the overthrow of § 24-301(d), or even reexamination of its validity. The question is whether it properly applied to appellant.

D. Appellant interposed the defense of insanity, thus requiring his commitment under 24 D.C. § 301(d) when the defense succeeded

Appellant does not seriously contest the District Court's finding that the defense of insanity was asserted for him at trial by his counsel, who "joined in" the defense and "actively sought an acquittal * * * on grounds of insanity." In essence, his quarrel with his mandatory commitment arises solely out of his own testimony at trial, and the question is not whether counsel raised insanity for him, but whether he disavowed counsel's actions, and whether the trial court properly proceeded to judgment.

In part, this contention rests on the over-simplified notion of counsel as his client's passive agent, a mere conduit for the client's desires, healthy or unhealthy, regardless of whether the client's short-term aims will serve his long-term interests. Here, perhaps appellant could get through this case, and perhaps through another, by asserting technical objections to the proof of charges of which he knew himself to be guilty. But he could not escape forever, nor would such 'beating the system' have any effect but reinforcement of the symptom-pattern of his illness, persisting in anti-social behavior to alleviate deep anxieties of personal insufficiency. He already faced other adult charges, for grand larceny by check, in Virginia, one of them evidently arising from the purchase of the gun involved here, although he had been an adult offender for scarcely a month when his confinement in this case began.¹³² Who can fault the judgment of his counsel and his mother, with which he apparently agreed, that he needed psychiatric commitment more than he needed an acquittal in a particular misdemeanor case, especially when that commitment might moot out felony prosecutions in another jurisdiction where insanity acquittals are not so easily achieved? His trial counsel's pleadings indicate some

¹³² Rouse was born August 5, 1944, and was arrested by Pvt. Bruce on September 7, 1962. He was apparently in continuous custody during the criminal proceedings.

knowledge of the Sociopathic Personality, and evidently of the need that treatment for appellant's illness be compulsory if it is to succeed.¹³³ His present counsel's contrary beliefs, four years later, come too late.

Appellant's argument seems to boil down to counsel's failure to pursue a motion to suppress. Although relevant authority strongly indicates that the legality of a search cannot be the subject of collateral attack upon a judgment,¹³⁴ appellant even seems to be litigating the validity of his motion to suppress in this Court. Ineffective assistance of counsel may be a catch-all assertion, but it should not allow a litigant to raise matters otherwise barred. Appellant's trial counsel evidently decided, quite correctly, that appellant's mental condition required treatment, and appellant agreed. To obtain such treatment, and to keep appellant out of jail on other charges, the motion to suppress had to be scuttled.

Appellant evidently acquiesced in this course of action. Judge McGarraghy so found, noting that his conclusion was "bolstered by the fact that petitioner did not complain of the result of asserting" the insanity defense until over a year later, when he executed the petition in H.C. No. 28-64. The court below thus found as a fact, having heard and observed appellant, that he "both sought and accepted the consequences of the acquittal by reason of insanity." That finding is not so clearly erroneous as to compel reversal here, and it carries with it the conclusion that 24 D.C. Code § 301(d) properly applied, the insanity defense having been raised by appellant's counsel, to compel his commitment to Saint Elizabeths Hospital.

CONCLUSION

WHEREFORE, it is respectfully submitted that the judgments of the District Court should be affirmed.

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FRANK Q. NEBEKER,

THOMAS LUMBARD,

Assistant United States Attorneys.

¹³³ See Noyes & Kolb, *MODERN CLINICAL PSYCHIATRY* 464-65 (6th ed. 1963).

¹³⁴ *Thornton v. United States*, — U.S. App. D.C. —, 368 F. 2d 822 (1966).

APPENDIX A

STAFF: PATIENT RATIOS--APA STANDARDS AND JOHN HOWARD PAVILION ACTUAL

Staff	JHP staff *			Staff: Patient ratio		
	Total	Admission and intensive treatment	Continued treatment	Overall	Admission and intensive treatment	
					APA	JHP
Physicians ^b	8	3	5	1:41	1:30	1:36
Psychologists	2	1	5	1:177	1:100	1:89
Registered nurses	11	4	6	1:32	1:5	1:30
Attendants	163	62	101	1:2	1:4	1:2
Hydrotherapists	0	0	0	(c)	1:50	(c)
Activity therapy workers:						
Registered OT's	2	1	1	1:177	1:100	1:133
Others (*)	7	3	4	1:51	1:40	1:44
Psychiatric social workers	2					
Dentists (reg.)	1					
Dental hygienists	4					
Laboratory technician	11					

JHP--1:214 admissions per year.
JHP--1:68 patients on leave.
JHP--1 supervisor: 6 case workers.

JHP--1:354--all services.
JHP--1:708 ^a--all services.
JHP--unavailable.^c

APA--1:80 admissions per year.
APA--1:60 patients on leave.
APA--1 supervisor: 5 case workers.

APA--1:1000--all services.
APA--1:500--all services.
APA--1:7500 procedures per year--all services.

^a Equivalent filled full-time positions.

^b Includes residents.

^c No hydrotherapy is carried out in JHP. There are 7 physical therapists assigned to PM & R who could administer this treatment.

^d We have no Dental Hygienists. This type of work is done by the Dentist or Dental Intern.

^e The ratio for the entire Hospital is 1:23,000 procedures per year.
^f "Includes such personnel as occupational and recreational therapy aides, physical education instructors, and music and dance instructors." STANDARDS 61.]

Prepared by: Biometrics Branch, SEH, December 9, 1966.

APPENDIX B

United States Court of Appeals for the District of Columbia
Circuit

No. 19,863

September Term, 1966

CHARLES C. ROUSE *v.* DALE C. CAMERON, *Superintendent,*
Saint Elizabeths Hospital

Before: BAZELON, Chief Judge, and FAHY, Circuit Judge,
in Chambers

Order

It is ORDERED *sua sponte* that the majority opinion in the above-entitled case is hereby amended as follows:

On page 5, add at the end of the carry-over paragraph the following footnote, to be numbered "18a":

^{18a} The plain language of the statute that "a person hospitalized in a public hospital for a mental illness shall * * * be entitled to medical and psychiatric care and treatment" should be followed even if the legislative history may be construed to the contrary. Moreover, the legislative history in this case may not properly be construed to the contrary.

The House Committee Report did make the broad statement that the bill did not apply to those committed in criminal proceedings. H.R. Report No. 1833, 88th Cong., 2d Sess. 3 (1964). The Report did not recommend enactment of this broad statement. It did recommend an amendment which defined a "mentally ill person" to exclude persons "committed * * * in a criminal proceeding." H.R. Report No. 1833, at p. 1. Since this definition was used in only a few sections of the Act, the Committee could not have based the broad

statement in its Report on the amended definition of a "mentally ill person." If the Committee had believed that its broad statement was literally true, it could not have thought there was any need for the amendment limiting the definition of a "mentally ill person." We cannot assume that the House acted inadvertently in failing to include either the Committee's broad statement in the bill itself or the term "mentally ill person" in the "right to treatment" section; nor can we assume that the Committee recommended—and the Congress adopted—a purposeless amendment. Likewise, if Senator Ervin's statement on the floor, that the House version of the bill applied only to "civil hospitalization procedures," 110 Cong. Rec. 21345 (1964), covered every provision of the entire bill, the amendment would have been superfluous for the same reason. And "hospitalization procedures" do not involve the right to treatment of a patient already hospitalized. In addition, section 17, now D.C. Code § 21-589 (Supp. V, 1966), as originally enacted, applied the "right to treatment" section only to those committed in "a noncriminal proceeding," but this section was afterwards repealed insofar as it related to the right to treatment. Compare 78 Stat. 953 (1964) with 79 Stat. 761 (1965). Although this change supports our construction of the statute, we cite it only to illustrate another contradiction in the legislative history. And our construction is not affected by other matters of legislative history. See, e.g., H.R. Report No. 1833, at p. 7; S. Report No. 925, 88th Cong., 2d Sess. 30, 40 (1964); 110 Cong. Rec. 14552, 20791, 20792, 21346 (1964).

Finally, in view of the clear language of the statute itself we should not impute to Congress an intent to discriminate among patients hospitalized in mental institutions.

APPENDIX C

THE QUESTION OF ADEQUACY OF TREATMENT

A POSITION STATEMENT BY THE AMERICAN PSYCHIATRIC ASSOCIATION*

Introduction

In 1966 the United States Court of Appeals for the District of Columbia Circuit ruled in substance that a person who has been committed to a mental hospital following acquittal on a criminal charge has a constitutional right to receive "adequate" treatment and that the court has a right to determine whether the treatment rendered is, indeed, adequate. Because of the precedent-setting nature of the ruling and its potential implications for psychiatric care facilities, it seemed incumbent on the American Psychiatric Association to formulate a psychiatric position on the issue as a contribution to the dialogue which may be expected in the wake of the Court's decision. Accordingly, APA's President appointed Dr. Henry A. Davidson as Chairman, and Drs. Oscar Diamond, Dale C. Cameron, Elvin V. Semrad, Joseph J. Baker, and Bernard C. Glueck Jr. as members of the Task Force to draft a statement. Their statement was reviewed by the Executive Committee of the APA Council on February 6, 1967 and approved with minor editorial changes as follows:

STATEMENT

The definition of treatment and the appraisal of its adequacy are matters for medical determination. Final authority with respect to interpreting the law on the subject rests with the courts. In any case, such definition and appraisal should take into account these seven basic considerations:

1. *The purpose of hospitalization and related treatment programs.*—(e.g. the problem is to direct the patient to the proper facility. A long-term care facility differs in purpose from an intensive short-term treatment unit in a community general hospital.)

2. *The relevance of diagnostic procedures.*—(e.g. Adequate diagnostic evaluation is an essential part of the total treatment process. The diagnostic and treatment plan must undergo constant revision as more knowledge is gained about the patient.)

3. *Protecting the patient.*—(e.g. There is need to prevent suicide and self-injury and to prevent acts harmful to others so far as possible. It would, manifestly, be "poor treatment" to release a patient to commit an unlawful act.)

4. *Interrupting the disease process.*—(e.g. There is frequent need to cut the patient off from narcotics, drugs and medications that may befuddle or toxify him, to separate him from acute stress situations, and to supply pharmacologic, dietetic, surgical and other medical measures to prevent the worsening of his condition.)

5. *Physical methods of treatment.*—(e.g. These include shock therapies, medication, treatment of incidental illness, and various somatic procedures.)

6. *Changing the emotional climate surrounding the patient.*—(e.g. The challenge here involves readjusting the patient's total environmental milieu,

*Approved by the Executive Committee of Council, February 6, 1967.

helping him to a more realistic appraisal of himself, changing his attitudes, remotivating him, providing him with new and improved social and personal skills in living and relating to the society about him. Such modalities as occupational therapy, music therapy, participation in patient government, halfway house experience, and many others contribute to the readjustment.)

7. *Conventional psychological therapies.*—(e.g. These include individual and group psychotherapies, pastoral counseling, social casework, and similar non-physical approaches to the patient designed to sharpen his understanding of both conscious and unconscious forces that impinge on his behavior. Through abreactions, reassurance, suggestion, reeducation, persuasion, exhortation, guidance, depth psychotherapy, and similar techniques, efforts are made to construct modes of behavior that will at once satisfy the patient's psychological needs and society's demands.

These seven categories are not discrete. They overlap. It is neither possible nor desirable to force a categorization of any single program under any single rubric. Nor will any one patient profit from all of the procedures cited. It is the responsibility of the physician to determine the appropriate treatment techniques to fit the individual patient's physical and psychological needs, assets and circumstances. Further, this determination must be made realistically in relation to the facilities, personnel, and objectives of the institutions, clinics, or agencies that are at hand.

Still, subject to these qualifications, the seven categories will serve usefully as criteria against which the adequacy of treatment may be assessed. They are presented as of possible use to courts and other agencies confronted with the problem of determining legitimacy and adequacy of treatment.

Cooperation of the Patient

Any comprehensive treatment plan requires a degree of cooperation by the patient to be effective and some procedures incidental to the plan require more cooperation than others. It is possible, for example, to give patients electroshock and medication without cooperation, and this may be done in an effort to make the patient more cooperative and receptive to other treatment procedures. Almost any form of conventional psychotherapy is extremely difficult to administer without cooperation and it may be said in general that the effectiveness of the psychotherapies is proportional to the degree of cooperation that is present. Some psychotherapies cannot be given at all without it. When cooperation is withheld the starting point of a treatment plan is to help the patient understand his need and to lead him to a more cooperative attitude. If a patient will not (or, more accurately cannot, because of the illness) cooperate, then it is neither obligatory nor sensible to attempt to force it upon him.

Perforce, the principle must be that a patient is entitled to any available treatment which will help him and which he (and his family in some instances) will accept. Regardless of whether a patient's refusal of treatment is willful or a product of his illness, it does not follow that his demand for release can be met because he has not received a treatment which he has refused.

Some Related Observations

Bona Fides

The United States Court of Appeals for the District of Columbia (*Rouse vs. Cameron*) has stated: "The hospital need not show that the treatment will cure or improve the patient, but only that there is a *bona fide* effort to do so." We are in full accord with the principle. Failure of treatment is always possible, but it must always be provided in good faith.

Treatment and Punishment

The conceptual contrasting of "treatment" on the one hand with "punishment" on the other sometimes obfuscates more than it clarifies the problem. Some courts, attorneys, statutes and judicial formulations reiterate, almost ritualistically, that hospitalization without treatment equates with punishment. This is not precisely the case.

Involuntary hospitalization clearly does imply restraint and may be properly viewed as a kind of punishment in a simple, unqualified context. But if such hospitalization is part of a treatment program aimed at interrupting a disease process (even though the treatment is refused or fails) it is not useful to dub it punishment anymore than it would be useful to view depriving an addict of the narcotic of his choice as punishment. The utilization of this kind of involuntary restraint may be viewed in one sense as analogous to problems encountered in child-rearing wherein there are no sharp delineations as between guidance and discipline or between discipline and punishment, all of which are directed towards putting internal and external limitation on unacceptable behavior. Restraints may be imposed from within by reinforcing a patient's inner defenses or from without, by pharmacologic means or by locking the door of a ward. Either imposition may be a legitimate component of a treatment program. Only if a patient were restrained and did not receive any of the treatments cited above could the restraint properly be called punishment. Further, it is unsound to dismiss a procedure as "purely custodial" or "purely punishing" without assessing the total circumstances in which it has been prescribed. The procedure is often of therapeutic value.

Individualization of Treatment

A program that has therapeutic value for one patient may be of no benefit to another. Some patients, for example, manifest acute anxiety when placed in open ward; others panic when placed behind locked doors.

Dangerous Patients

On the basis of long experience, psychiatrists estimate that about 90 percent of all mental hospital patients are harmless and in no way threaten the community in which they reside. Admittedly, however, the other 10 percent comprise roughly 60,000 patients and protecting the community from irresponsible acts they might commit is a priority social concern. To release them prematurely is never justified regardless of the adequacy of treatment they may be receiving. The constructive way of approaching this problem lies in obtaining the staff and facilities for providing adequate treatment, not in premature release.

Alternate Dispositions

A mental hospital is not always the best possible facility for providing adequate treatment. At the same time it should be appreciated that it may not be in the interest of the mental hospital patient, especially the confused, severely depressed or senile patient, to thrust him out of the hospital even though the treatment setting is not ideally suited to his needs. The point is, however, that all possibilities for securing adequate treatment should be explored—general hospitals, out-patient clinics, day treatment centers, private practitioners, halfway houses, nursing homes, and many others. Such exploration is the proper function of the family physician, the social agency, and the patient's family and not of the court or the hospital. If there are no such facilities then, of course, the mental hospital may be the best solution to meet the needs of patient and community, but referral to it should not be a matter of routine.

The Total Milieu

All parts of the environment surrounding a patient have impact upon him. The total effect of his overall milieu cannot be explained by analyzing each part of it separately. In one hospital ward setting all decisions may be made for him—when he will shave and shower, when and what he will look at on television, etc. In another ward situation general permissiveness may characterize the milieu. Either situation may have therapeutic or anti-therapeutic effect on the disease process.

The Incurable Patient

The late Dr. Winfred Overholser, long time superintendent of Saint Elizabeths Hospital in Washington, D.C., often reiterated: "I do not believe that we should write off any patient as incurable. We are going to try our hand at treating every patient who is sent to us." The profession of psychiatry must endorse this statement notwithstanding acknowledgment that its science cannot yet prevent lifetime hospitalization for a few. One can only keep trying with the knowledge and skills at the profession's disposal and in the hope that research will be ever productive of new knowledge that will make the effort more effective.

Staff Shortages

In general, there appears to be a positive relationship in mental hospitals between small size and larger staff-patient ratios and the rate of recovery of patients. That is, a mental hospital with more than 1000 beds and with 25 employees per hundred patients gets poorer results than a smaller hospital with 250 employees per hundred patients. The model "Draft Act" governing hospitalization of the mentally ill recognizes this in stating that "every patient is entitled to treatment to the extent that facilities and personnel are available." Some courts appear to reject this principle and say in effect that lack of staff is no excuse for failure to treat a patient, and that if ideal staff ratios cannot be maintained to provide adequate treatment then the patient should be released. We think this doctrine is tantamount to an oversimplified gospel of perfection. Clearly, in perspective of the overall mental health manpower shortage in our country, one must settle for something less until personnel shortages can be overcome.

The Ultimate Responsibility

The ultimate responsibility for the relative adequacy of psychiatric treatment facilities rests with the community. Day by day responsibility for operating and administering these facilities rests with a professional staff accountable to the community for its performance. The staff must respond to criticisms of its work from any responsible civic source. Nevertheless, the staff must have authority, day by day, to determine priorities in the use of personnel, to appraise patients' progress, and in all other ways have freedom to operate the facility in the best interests of the total patient population. Mental hospital administrations may vary in quality as do all human institutions. It is one thing, however, for outside community agencies to render constructive criticism of the relative adequacy of a psychiatric facility, and quite another for it to interpose its judgments on the professional managerial affairs of that facility. The former must be welcomed. It is doubtful if the latter will enhance the quality of administration.

